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Summary of the FMA Board of Governors Meeting
June 29, 1985

The following is a summary of the major actions taken by the Board of Governors at its meeting June 29, 1985.

THE BOARD:

Future PLI Efforts

Approved the following policy in respect to future PLI activities of the Association:

The Board of Governors expressed support for any one or all of the following elements for additional tort reform during the 1986 Legislative Session:

- Elimination of joint and several liability
- Elimination of mandatory insurance for physicians
- Cap on general damages (non-economic)
- Removal of the resolution of professional liability cases from the tort system

The Board further approved the following overall policy in respect to the professional liability issue:

- That FMA staff be directed to study and evaluate the proposal for removal of the resolution of professional liability cases from the tort system and report its evaluation to the Board of Governors.
- That FMA will continue to review the effectiveness of the Comprehensive Medical Malpractice Reform Act of 1985 and seek any appropriate and feasible changes during the 1986 Legislative Session.
- That FMA continue to explore with other organizations identification of appropriate issues and support for those issues in respect to a constitutional initiative.

Programs and Priorities 1985-86

Approved in principle the proposed FMA programs and priorities for 1985-86 subject to review and input by component medical societies and final consideration by the Board of Governors at its October meeting. (Attachment)

Statewide IPA Study

Approved an immediate study by FMA in respect to the feasibility of the Association seeking to establish an FMA sponsored statewide prepaid health care plan.

Candidates for AMA Elective Office

Enthusiastically endorsed the candidacy of Rufus K. Broadaway, M.D., for President-Elect of the American Medical Association and J. Lee Dockery, M.D., for reelection to the Council on Medical Education of the American Medical Association at the 1986 AMA Annual Meeting and approved appropriate funding for campaign expenses from Association resources and other sources to be identified.

1986 Annual Meeting Dates

Established September 17-20, 1986 as the dates for the 1986 FMA Annual Meeting and further selected the Diplomat Hotel as the site of the 1986 Annual Meeting due to more favorable contractual arrangements.

Attendance at Board of Governors Meetings

Approved advising county medical society presidents and executive directors that they are welcome to attend, at their own expense, all Board of Governors' meetings, including the Fall Meeting.

Medical/Legal Hotline

Approved guidelines for the implementation of the FMA Medical/Legal Hotline to be established effective July 1, 1985.

Medical Practice Act Licensure Exemption Law

Authorized the President and FMA Legal Counsel to explore the constitutional aspects of the Licensure Exemption Law passed during the 1985 Legislature.

COUNCILS AND COMMITTEES

The Board reviewed reports and recommendations from FMA Councils and Committees and took the following actions:

Non-PLI Legislative Priorities

Approved the following non-professional liability legislative priorities for the FMA for the 1986 Session, and authorized staff to begin appropriate review of these issues and develop recommended policy and support information on each issue prior to the October 1985 Board of Governors Meeting.

- Sunset review of the Medical Practice Act
- Sunset review of Allied Health Professionals
- Certificate of Need
- Designation of trauma centers
- Indigent health care funding
- Reorganization of the Department of Health and Rehabilitative Services (DHRS)
- Foreign Medical Graduates
- The Law of Medicine

COUNCIL ON HOSPITAL MEDICAL STAFFS

Council Appointments

Approved appointment of the following individuals from each FMA medical district to serve on the Council on Hospital Medical Staffs.

District A - North Medical

Richard W. Cunningham, M.D., Alachua County
Robert P. Johnson, M.D., Capital

District B - West Medical

Marc Freeman, M.D., Pasco County
Ray Barnes, M.D., Polk County

District C - East Medical

Richard W. Snodgrass, M.D., Volusia County
Leonard Erdman, M.D., Broward County

District D - South Medical

Joseph Harris, M.D., Dade County
Esteban Valdes-Castillo, M.D., Dade County

Risk Management Committee

Approved the following nominations for appointment to the Risk Management Committee of the Council on Hospital Medical Staffs:

Charles P. Gibbs, M.D.
Eric Geiger, M.D.
Francis L. Howington, M.D.
Howard A. Hogshead, M.D.
Paul Gluck, M.D.
Herbert Aronson, M.D.

Mandatory Insurance

Approved referral to the President and to Legal Counsel for determination of the appropriate Association action regarding the issue of the mandatory insurance coverage requirement that is being mandated by certain medical malpractice insurers in the state who are requiring physicians with hospital privileges to maintain $1 million in malpractice coverage as a condition of insuring the hospital.

COUNCIL ON MEDICAL SERVICES

Drug Education Performance Standards K-12

Approved the recommendation that the Florida Medical Association endorse the Florida Alcohol and Drug Abuse Association's "Drug Education Performance Standards K-12"; and further approved that FMA urge the Florida Department of Education to use this booklet in planning curriculum for kindergarten to grade 12 subject to review and approval by the Council on Scientific Activities.

COUNCIL ON MEDICAL ECONOMICS

Professional Foundation for Health Care

Authorized the FMA to establish liaison with the Professional Foundation for Health Care, Inc. (PFHC), in order to develop a mechanism to effectively address problems which have been created by the present statewide PRO.

Council on Hospital Medical Staffs

Approved the recommendation to request the Council on Hospital Medical Staffs to invite representatives from each hospital in the state to notify the Council of any problems they have encountered with the PRO for their review, study and forwarding of this information to the Committee on PRO for their review and action.

Certificate of Need

Approved the recommendation that the Statewide Health Council be requested to include physician representation from nominees recommended by the FMA to participate in the Certificate of Need Task Force proposed by the Statewide Health Council.

COUNCIL ON SCIENTIFIC ACTIVITIES

Mandatory Continuing Medical Education

The Board was advised that the Chairman of the Council on Scientific Activities was in the process of establishing contact and liaison with the Department of Professional Regulation for the purpose of beginning dialogue in respect to the recently adopted legislation which requires at least sixty hours of continuing medical education every three years for physicians.

JUDICIAL COUNCIL

Physician Discipline and Fee Disputes

Authorized the President of the FMA to appoint an ad hoc committee of the Judicial Council to study the need for changes in the handling of grievances against members and the establishment of a streamlined procedure for handling other complaints and fee disputes and that the committee be charged with making specific policy recommendations to the Board.

COMMITTEE ON IMPAIRED PHYSICIANS

Appointment of Advisory Member to IPC

Approved the selection of Larry Gore, DVM, CAE, of Orlando, Executive Vice President of the Florida Veterinary Medical Association as an advisory member of the Committee on Impaired Physicians.

FLORIDA PHYSICIANS ASSOCIATION

Newly Elected Officers

Received an informational report from the Florida Physicians Association in respect to newly elected officers. The following were elected:

Charles J. Kahn, M.D., President
John A. Dyal Jr., M.D., Vice President
Miguel Figueroa, M.D., Secretary
Warren M. Barrett, M.D., Treasurer

Collective Bargaining

Received a report that the FPA is investigating the legalities affecting the FPA in serving as a third party collective bargaining agent for the Association's members.

FLORIDA MEDICAL POLITICAL ACTION COMMITTEE

PLI Voting Records

The Board received an informational report in respect to FLAMPAC membership and the 1985 professional liability voting records. The Board was advised that a two-day meeting of the FLAMPAC Board of Directors will be held July 26 and 27, at which time FLAMPAC will begin targeting 1986 campaigns and approving programs for the coming year.

REPORT OF PUBLIC RELATIONS OFFICER

Future Activities

The Board received an in-depth report from the Public Relations Officer on current, short-term and long-range public relations activities of the Association. A broad-based and ongoing public relations program is being developed and will require a major long-term commitment by the Association in both time and financial resources. Moreover, it will only be successful if it is properly coordinated with the AMA (see item re AMA public awareness campaign) and FMA component medical societies and specialty groups and, perhaps most important, if individual physicians are willing to participate as an integral element of any program. The program must begin and end in the physician's office or his/her contact with people in any setting. The most effective public relations comes from the grassroots level. Physicians must become more aware of their individual image, particularly in the area of patient relationships. If physicians are alienating their patients, our public relations program will be facing an uphill battle. Therefore, a top priority will be to develop training programs in patient relations for physicians and their office staffs.

Efforts will be made to organize a panel of physicians from differing specialties to discuss patient relationships and varying problems of the office practice and physician/patient relationship. If the major real or perceived problem areas can be identified, we will be better equipped to design a more effective educational or behavioral-type program.

Some preliminary ideas as to the methods of developing a patient relations training program for physicians include:

- A program for either the next Leadership Conference or Annual Meeting
- Develop a program which the county medical societies could administer
- Develop periodic columns on the subject for the Association's monthly newsletter, *FMA Today*, and *The Journal* of the FMA

Another potential area for development at the grassroots level is communicating messages to patients in the physician's office waiting room. The FMA is exploring the possibility and feasibility of initiating a mechanism whereby physicians could, at a reasonable cost, install VCRs in their waiting rooms. These would be used to show a variety of medical programming or medical-related issues to patients waiting to see their physician. The FMA would develop programs for video taping as well as use existing materials. This is a long-range project which will require in-depth study and investigation before implementation.

Another area of activity is the publishing of a quarterly newsletter targeted for state legislators and the Congressional Delegation and other selected government officials. Through

this newsletter, FMA would seek to keep legislators and government administrators updated and informed about medical issues impacting physicians and the general public.

Developing speakers bureaus at the county medical society level is an important priority as well as developing some young, dynamic physicians to be spokespersons. The FMA will work with the AMA Communications Department to develop a mechanism for conducting speaker's training courses in Florida on an ongoing basis.

AMA DELEGATION

The Board received a report from the Chairman of the AMA Delegation in respect to the delegation activities during the 1985 AMA Annual Meeting June 16-20 and the actions of the House of Delegates. The House considered approximately 155 resolutions from constituent state medical associations and national specialty groups as well as numerous reports from the Board of Trustees and AMA Councils. The following is a summary of the major actions of the House. A more complete report will be included in *AM NEWS* and future FMA newsletters to the membership.

Medicare Program

Report EE of the Board of Trustees was a brief report on studies of fiscal stability of Medicare, which informed the House that it is studying development of a Health IRA proposal to improve the program's financial soundness. Resolution 16, "Health Individual Reserve Accounts" (H-IRA) and Resolution 89, "Endorsement of IRAs", both call for the conditional support by the Association of Health-IRAs. The House adopted these Resolutions.

Resolution 18, "Direct Provided Payment for all Medicare Medical Services" was adopted by the House. This Resolution asks that the Association seek direct payment to providers by Medicare whether or not the provider accepts assignment. There was considerable debate on this Resolution because it would require a change in the law, not merely in regulations.

Resolution 38, "Capitation Programs for Medicare Recipients" was adopted. This Resolution calls for regulations which would require Health Maintenance Organizations and Competitive Medical Plans to fully explain ramifications of membership to Medicare eligibles and for HRS to verify performance capabilities of such plans before awarding them contracts.

The House adopted Substitute Resolution 110 which concerns Medicare payments. The Resolution states:

RESOLVED, That the American Medical Association requests that the Health Care Financing Administration direct Medicare carriers in each state to reevaluate the data and methodology used in calculating customary profiles in the local prevailing fee screens for all physicians, and that three customary charge profiles be made available promptly to each physician, when requested, for review and verification, and be it further

RESOLVED, That the American Medical Association continue its opposition to the limitations on increases in the customary and prevailing charge levels for Medicare reimbursement and its opposition to the freeze on actual fees for services provided Medicare beneficiaries.

Health Care Funding for the Financially Disadvantaged

Report A of the Council on Medical Service entitled "Closing the Gaps in Health Care Funding" was adopted by the House. This is a detailed report on the amount of uncompensated care provided by physicians, the types and estimated number of patients receiving such care, and potential solutions. It was further recommended that this report receive wide dissemination, especially through AMA media sources. This is a subject of critical importance that requires continued study and future reports regarding the issues of financing coverage and availability of adequate health expense coverage.

Professional Liability

The House approved two reports on the Association's activities in Professional Liability. Report 00 is a report by the Committee on Professional Liability on its study of professional liability plaguing obstetricians and gynecologists and Florida physicians in recognition that both groups are facing a special crisis involving both affordability and availability of professional liability coverage.

Report AA details the program of the Association's Special Task Force on Professional Liability and Insurance, highlighting the Action Plan developed by the Task Force and many activities undertaken in implementation of the Action Plan to date.

Two other Resolutions were adopted by the House concerning the malpractice crisis. Resolution 149, entitled "Malpractice Crisis" directs the AMA Board of Trustees to urge the Special Task Force on Professional Liability and Insurance to consider all means to inform the general public concerning the

malpractice crisis. It also urged an AMA appeal to the Federal Government and local medical society appeals to state legislators and governors, to propose solutions to the professional liability situation.

Resolution 155, entitled "Liability Media Campaign", directs the AMA immediately to begin preparation of an expanded and more specific response to the American Trial Lawyers Association's contentions regarding the current situation in professional liability and to make the resulting rebuttal to ATLA contentions available for use by advocates of tort reform to counter and dispel ATLA's arguments before the public. The Resolution was amended to reflect the fact that the Association has already begun developing a response to the ATLA's agruments.

Medical Staff Section

The Hospital Staff Section submitted 13 Resolutions to the House of Delegates concerning physician/hospital relations. Of these 13 Resolutions, 7 were adopted, 3 will be addressed at the Interim 1985 Meeting, 2 were referred to the Board of Trustees, and 1 was not adopted.

Following are the Resolutions which were adopted:

Resolution 149 - Malpractice Prices

Resolution 152 - Support for Inner-City Hospitals

Resolution 150 - Guidelines for Outpatient Surgery and Same Day Admission

Resolution 151 - Physicians Statement on the Federal DRG Program

Resolution 147 - Hospital Administrator and Medical Executive Committees

Resolution 153 - The Report of the Joint Task Force on Hospital Medical Staffs Relations

Resolution 145 - Utilization Peer Review

Alternative Delivery System

The House of Delegates considered and adopted several Resolutions relating to Alternative Delivery Systems including Resolution 54 presented by the Florida Delegation. This Resolution was combined into Substitute Resolution 43. It calls for legislation to revise federal policies so that employees must make traditional fee-for-service coverage as an option to employees whenever employers are mandated by law to offer an HMO option for health care services.

The House also adopted Resolution 90, "Medical Society Sponsorship of Statewide IPA/HMO". This Resolution calls for the AMA to monitor the Medical Association of Georgia Independent Practice Association/HMO Plan and determine if its widespread use would be beneficial. The House also reaffirms support for the indemnity payment system and to seek immediate implementation of it at the national level.

Peer Review Organizations

Report H of the Council on Medical Service reported on the status of the Peer Review Organization (PRO) Program. The Council concluded that the current Association policy on Peer Review remains appropriate but that it should be continually reassessed in light of new developments in the PRO Program. Testimony received also indicated some specific problems with the PRO Program, such as some PRO's establishment of standards of care in medical protocols without the appropriate involvement of practicing physicians. These matters will be included in future Council studies. Resolution 105, "PRO Appeals Process" was adopted by the House. This Resolution favors changing federal legislation to allow physicians access to an administrative hearing or judicial review of an unfavorable reconsidered decision by a PRO.

Alcohol and The Driver

Report A of the Council on Scientific Affairs described the Council's study of alcohol and drivers, recommending among other things an AMA program including public information against drinking by drivers; support of legislation establishing a 0.05% blood-alcohol level as conclusive evidence of drunk driving; supporting 21 as the legal drinking age; supporting state legislation calling for administrative suspension or revocation of drivers' licenses after driving under the influence; and encouraging industry efforts to develop a safety mechanism that thwarts operation of a car by an intoxicated person.

Public Awareness Program

At the Interim Meeting, the AMA's House of Delegates adopted Report 00 of the Board of Trustees and Substitute Resolution 2. These actions call for the Association to develop a wide range of activities aimed at informing the public of changes in the Medical Care Delivery System and increasing the public's awareness that physicians are their patients best advocate in safeguarding the quality of medical care in the United States.

Report RR of the Board of Trustees presents a five-point program which has been developed by staff working closely with nationally recognized experts. The funding of projects included is based on a major redirection of current Association activities. The program, to be implemented in 1985, is designed to

strengthen and reinforce but not substitute for the Association's long standing communications activities.

This program reflects two fundamental considerations — the need to:

- monitor and evaluate each project on a limited market basis because of the lack of research on the relative effectiveness of different strategies.
- target each activity to the state and county level for maximum federation involvement and impact.

Elements of the five-point program include:

State Surveys for Program Evaluations

The AMA will conduct base-line surveys on the public's views toward medicine and physicians in all 50 states.

Production and Evaluation of Television Infomercials

The AMA has been for a number of years very successful in producing and obtaining TV air time for its award-winning public service announcements (PSAs). Recently, a number of not-for-profit associations has begun to explore purchased air time as a more direct way of communicating with the public. In this regard, the informational commercial, or infomercial, is gaining popularity. The AMA will produce one infomercial with the content emphasizing the impact of changes in the medical care system and the vital role that physicians play as advocates for their patients. Following production, the infomercial will be aired during prime time in a test market for approximately 10 days.

Promotion and Distribution of Physician Profile Film

The AMA has completed production of a documentary/drama on physicians and the current practice of medicine. Profiles of physicians in a variety of professional and geographic settings have been included. The primary focus is on the many changes that are occurring in American medicine today and how physicians serve as caring advocates of their patients' rights.

This film will also be test marketed before general release. Public distribution will be through a theatrical release package developed and coordinated by an external booking agency. Outlets are primarily theatres, but can also include cable and satellite television link-ups.

Public Health Campaign Pilot

To increase public visibility for local and state associations, the AMA will provide several state and county societies with the basic framework necessary to conduct the pilot Public Health Campaign. The local society will sponsor an extended event, based on the public health theme, which will involve community action, physician participation, and public service.

National Communications Workshop

There is widespread agreement that the success of any public relations image program depends upon a local, as opposed to a national, focus. For this reason, the communications/public relations staff and activities of the Federation constitute a major resource for both planning and implementing an ongoing awareness program.

To effectively mobilize this resource, staff from the Federation will meet for an annual communications forum in Chicago. The meeting will address communications problems and successes in a broad range of areas. Opportunity will exist for communications education sessions on spokesmanship training, "Training the Trainers," building media relations, and other issues.

The National Communications Workshop will consist of a 1½ day session held in Chicago during October on an annual basis.

AMA Trustees Elected

The Delegation was delighted to report the election of Rufus K. Broadaway, M.D., for a second three-year term as a member of the Board of Trustees of the American Medical Association. The delegation has expressed its full support for Dr. Broadaway's candidacy for the Office of President-Elect of the AMA at the 1986 Annual Meeting.

Nominations

The Board of Governors also enthusiastically endorsed the nomination of Frank C. Coleman, M.D., to the AMA Task Force on Professional Liability and Louis C. Murray, M.D., to the Council on Legislation.

Dues Increase

The Board was advised that the AMA House of Delegates approved a $45 a year dues increase to become effective January 1, 1986. The increase will establish a dues level of $375 for regular members.

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

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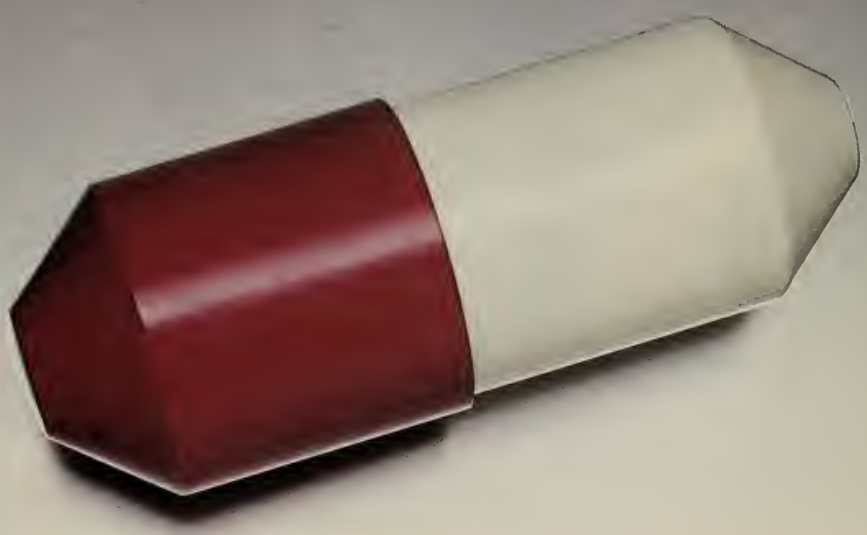

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This month's cover features the winner of the Editor's Award in the Ninth Annual FMA Auxiliary Benefit Art Show. The photograph is entitled "Purple Vein" and was taken by Ms. Michele Schiebler. Michele is the daughter of Dr. and Mrs. Gerold L. Schiebler.

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FMA's public education program

By this fall a public education program by the Florida Medical Association should be organized and functional.

This program will be two-fold, first emphasizing the advantages of a private practice of medicine and of those systems which are organized and directed by physicians, keeping as a priority the quality of medical care and the principle that we treat patients as a whole and not as isolated diseases.

We are being forced by the government and entrepreneurs, whose eyes are only on economics and the bottom line of a balance sheet, to classify patients by a "cookbook" type system through the DRG concept.

The second part of this program will be to improve the image of the physician in general. According to the latest national surveys, physicians are depicted as cold, impersonal, detached individuals who spend health dollars with contempt and without considering the economics of the patient or the nation as a whole.

We know that none of this is true. We know that most of us work hard and long, keeping in mind the well being and good care of our patients and trying to be as efficient as possible in our professional attitude. However, we can not compromise the quality of care that warrants our patients the fastest, complete recovery, which is the most economical and efficient way to return the individual to gainful employment with less disabilities and the maximum enjoyment of life.

We must begin by educating ourselves to transmit these ideas to our patients, a captive audience with which we have a rapport and who are willing to reason on a one-to-one basis and understand these facts.

As part of this program, we must develop speakers' bureaus within each county medical society and inform civic and religious organizations that these bureaus exist and that members are willing to address any group of interested individuals. The idea we are trying to convey to our members is that the work of this program must be personalized from the grassroots upward. Television, radio and newspaper ads will not do the work we really need; they can help in increasing the public's awareness of the health problems that face our state in particular and the nation as a whole. However, they will never replace the warm body of a speaker who is willing to reason with a group of individuals, answer their questions and put to rest their concerns, correct the misconceptions and falacies that for years have been built up by interested parties in a constant, persistent, methodical manner.

We must all work together and become more active in the public arena. It is our common problem, and the solution depends upon each and every one of us.

With organization and enthusiasm, with logic and reason based on our high standards of moral and ethical principles, we can change the perception of our profession.

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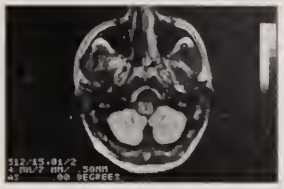

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EDITORIALS

Cracks in the image or What patients think of us

Physicians recently have been suffering from an unusual affliction: bruised egos. Polls taken the past few years have shown unmistakably that the public is changing its perception of the medical profession. While most Americans still revere their doctors, a growing number of them are also getting disenchanted. This change in attitude has caused ripples of discontent in the profession, and there is now a swelling tide of urgency that physicians must do something to restore their image. The AMA and the FMA underscored the importance of the problem when both organizations decided that improving the public image of physicians would be one of their top priorities for this year.

Physicians who have been feeling the public pulse through polls conducted for the AMA and other organizations may feel that the picture is not as bad as it looks. Perhaps so. After all, majority of those questioned still expressed satisfaction with their individual physicians and in their professional abilities. But what about the other things that increasing numbers of Americans believe in? They are disturbing, and here they are: we went into medicine mainly for the money and prestige; we don't care about people as much as we used to; and we are not spending as much time as we should on patients. That is a short litany of shortcomings but they strike at the very heart of our profession. We should have reasons to be concerned; if things do not get any better, one can only imagine what the public will be saying about us a year or two from now.

Those of us who have been practicing our profession for years and who have been doing a good job probably should feel less concerned about these perceived problems in our image; we can always comfort ourselves with the thought that only a few physicians are causing these problems and that, with time, as we ferret out the bad elements from our ranks, our public image will start glowing again. But it is not as easy as that. Skirting the problem in this manner is probably the worst thing we can do. Public perceptions, whether true or not, are hard to die, and can cause the medical profession irreparable harm unless they are dispelled or corrected. The prospect of having a poor public image should never escape us: look at all the trades and professions that have never lived down their bad image because of the lasting imprint that it leaves on the public consciousness. The volatile environment in which we now practice, where physicians are in hectic competition for the shrinking health dollar, may make us vulnerable to the kind of things that the public is accusing us of.

Any activity or program that physicians should embark on, either individually or collectively through their medical organizations, should focus on those things that, in the public judgment, are tarnishing our image. This requires examining what patients are telling about us, dispelling them where they are false, acknowledging those that are true and taking steps to correct them, and educating the public about them. We may be surprised that patients are telling the truth about us more than we care to acknowledge.

Is there any truth, for example, to the growing public perception that physicians entered the profession of medicine primarily because of the prestige and the money? The question may sound revolting, mocking as it does the noble roots of the profession, the unmatched record of service of physicians to their fellowmen, and the altruistic ideals of young men and women who are following their profes-

sional forebears. That may be true; unfortunately, begging the question and invoking the past and the traditions of the profession are not enough nowadays. But what about the intellectual challenges, the professional and personal satisfaction, and the ability to practice a profession with so many splendid opportunities unmatched by any other calling? Those are probably more compelling motives than purely material considerations. Sure, sure, we all know about these things; and so does the public. The practice of medicine is all these; 44% of Americans, however, believe otherwise. Can they be right?

They are only partially right. Not all physicians are altruistic or intellectually challenged by medicine; there are those who no doubt became physicians because of the boundless opportunities to pile up money and to bask in the public glow accorded to members of the medical profession. But they are a small minority. Nevertheless, it is these few scoundrels who give the whole profession a bad name.

Side by side with the perception that physicians are motivated mainly by money and fame, the same poll respondents think that physicians are charging excessive fees. Again, this is probably true for a small number of physicians, and it is bolstered by common knowledge in the profession of certain medical procedures and services fetching handsome financial rewards out of proportion to the time and skills involved. The internecine snipings of one segment of physicians against another about the disparity in fees between cognitive and procedural services make us feel uncomfortable about fees. But there is one bright note. Where only 32% of those questioned in 1983 felt that their physicians' fees were reasonable, 71% in 1985 feel that physicians' fees are reasonable. It is obvious that the freeze on Medicare fees by the government had a lot to do with this dramatic shift in public attitude.

Fifty-four percent of patients also believe that physicians are not as compassionate as they once were. This is nothing new; what is new is the increasing number of people who believe so. The usual reason given by physicians for this public belief is that the traditional family physician who held hands with Grandma and comforted the family in a night-long vigil is gone; in his place is the superspecialist whose focus is narrow and whose armamentarium consists of the use of high technology instead of the warm and personal relationship that the caring and compassionate physician of old has developed into an art. There is nothing wrong with narrow and specialized care; the advent of advances in all fields of medicine has made this necessary. Modern physicians are fond of saying that being able to diagnose and treat a patient's problem is the greatest act of compassion. That is true to a certain extent, but many of us are also familiar with stories of countless patients who have been brutalized by the coldness, the impersonality, and the brazen lack of feelings by many physicians. A fusion of caring and high technology should not be incompatible.

A still bigger number, 61%, believe that physicians do not spend as much time on patients as they used to. Part of this is related to the thinning ranks of primary care physicians, who usually spend the most time with patients, and to the ever increasing number of specialists whose busy schedules restrict them from taking the time to get intimately acquainted with their patients. The story of patients who wait for two to three hours to see the doctor and then get dismissed after a five-minute visit has become a familiar refrain to us. In addition, the highly competitive environment may be forcing physicians to see as many patients as they can in their offices, leaving them little time to sit down and explain things to patients. The new types of health care delivery systems, with their impersonal character, their big patient loads, and their emphasis on economics, also do not foster an atmosphere where physicians are given adequate opportunities to spend time with their patients. There is probably little we can do about some of these things; at the same time, the fact that the public is complaining about them should sensitize us to the problem and realize that patients want more than a cursory examination or a hurry-up job.

It should be obvious, from examining these public attitudes, that there are cracks in our image; equally obvious, we must act to stop these cracks from getting bigger. The favorable public image that we have had for years is rooted in tradition and our ideals of service; it is what makes medicine a unique and noble calling. We need to preserve that. We must assure the public that even though medicine is going through a troubled period, its focus will always be on providing humane care for people and preserving the excellence of that care.

What can we do to project the best image for ourselves and for our profession? Plenty, both individually as practitioners and collectively as members of our medical organizations.

Physicians as individual practitioners have a far better image than as collective members of organized medicine. That should afford them a better vantage point to discuss with patients what their concerns are. If we have been remiss in the past, we now must listen and take more time with them, make them feel that we care for them as people, and charge only what is reasonable. Whether we are generalists or specialists, we must employ technology not to abridge our relationship, but to complement the human warmth that is often frozen by the cold stare of our machines. We also must educate patients about the many changes in medicine, the repercussions of these changes to the future of medical care,

and the necessity to accept reforms and to reject those things that will destroy our current medical system. Having patients on our side will be helpful in our forthcoming battles in the political arena. There are other small things that patients appreciate from their doctors: a smile, a pat on the back, a helping hand, words of encouragement, a cheerful attitude from the office staff, and an offer to fill out the insurance forms. There is little glamour in doing these things, only the satisfaction of helping people, which is the hallmark of our profession.

It is in the collective efforts of organized medicine, from the county medical societies to the AMA, that physicians should be doing a better job at boosting their public image. Our leaders of medicine are cognizant of this. AMA President Harrison L. Rogers Jr., M.D., in his inaugural address, targeted the improvement of physicians' image as one of the four main issues facing the medical profession today. Closer to home, the FMA Board of Governors at its meeting on June 28 approved as one its goals and priorities for 1985-1986 the development of a public relations program designed to build and maintain a positive image of physicians. The program envisions, among other things, the formation of PR committees at the county medical society levels to supplement the FMA program, strengthening the FMA Speakers' Bureau and encouraging the formation of such bureaus within county medical societies, development of programs to help physicians and their office staffs in improving communications and relationships with patients, publication of a newsletter targeted to public officials, and greater involvement with the media in the dissemination of news and expression of the profession's views on items affecting medicine.

The success of any campaign to polish our image both on the grassroots and the national level will require the full participation of physicians. The usual apathy of the past must be replaced by vigorous involvement. There are smug physicians among us who could care less and who feel that polls do not reflect the true situation. This is the kind of thinking that will set back our efforts to advance our cause. Our sagging public image is real and requires concerted action. For those of us who care about our profession, who feel obliged to preserve the best of our heritage, and who feel sensitive to the needs of the public, we must do our share to project ourselves in the best light possible. Our patients are telling us something. If we don't listen to them, nobody else will listen to us.

R. G. Lacsamana, M.D.
Editor

The demedicalization of America

After thirty years of increasing delivery of medical care to the public, the federal government has done an about face. We are now in the midst of an effort to "demedicalize" America. This is a very interesting phenomenon and represents an attempt to redirect the health care policy which has existed in the United States since World War II. It is an effort to return the concept of the delivery of medical care to the days of the 1920's and 1930's. It was during these years that America was in a demedicalized state. This was through no planned action or concerted effort, but was the result of the evolution of medical care to that point in time. Prior to World War II, there were only a few significant advances from a scientific standpoint. Most of the great achievements in the decades prior had been through public health measures and not through technological advances. The control of malaria, hookworm, scurvy, and other diseases was not through medicine or technology, but by careful observations and changes in diet, environment, or personal habits. There had been advances in trauma and surgery, largely as a result of the opportunity afforded by the Civil War and World War I. However, there were few diagnostic tests widely used other than the x-ray in the 1930's. There was no expensive technology and hospitals were still in their infancy. Many small or medium-sized cities did not even have a hospital then.

Americans did not expect much from the medical profession. They were content with physicians being the comforters of the sick, not especially the healers of the sick. In most illnesses, physicians were powerless to alter the outcome. The active role of doctors was largely confined to good nursing care and comforting the patient and family. Diseases ran their courses and neither physicians nor the armamentarium at their disposal usually altered events. As such, America was demedicalized by virtue of its own medical history. We had never been "medicalized." While physicians and medicine were respected, often the medical care of an individual was left to him and his family as they knew that the medical system had little to offer. The doctor was called on only as a last resort and then largely to confirm what was already suspected.

The federal government, the public, and the medical profession lived in this state of affairs until the outbreak of World War II. If there is a dividing line between the events which went before and those which followed, 1941 would be that line. With

the outbreak of World War II, America would embark on three decades of trying to prove that more medical care and more medicine was better for America. It was a period of time when America was truly medicalized. In the process, our mores, concepts of health care and the economic aspects of the health system would undergo tremendous change and America would never be the same.

The changes were subtle at first. The military recognized that more training or specialization was desirable and those with special training entered the armed forces as a captain and the generalist entered as a lieutenant. By this difference in rank, the federal government showed that more was better and would be rewarded. Physicians recognized that specialty training appeared to be what the federal government wished. For this reason, the advent of specialty training would evolve out of the attitudes of military medicine during the war. Of course, there were other factors leading to specialization, but the war was the culmination and the pivotal point from which specialization would flow. Specialization was further enhanced by the fact that the federal government would start pouring millions of dollars into training programs and research designed to help turn out the specialist.

The war gave the opportunity for increased antibiotic usage with the production of pencillin on a large scale. Suddenly, diseases that were incurable a few years before were now miraculously cleared up with a few injections of penicillin. There were other technological advances brought on by the war, such as blood banking, new surgical techniques learned on the battlefield, and the administration of a large medical care system with its thousands of hospitalized patients. The war provided the initiative and the opportunity for the expansion of the role of the federal government. The nation was impressed by the advances and by the end of World War II was psychologically ready for a rapid move to the medicalization of this country. The government moved rapidly to control and direct the movement. In 1946, the Hospital Survey and Construction Act, better known as the Hill-Burton Act, was passed. This provided funds to individual states for the planning and construction of hospitals. Since that time, several amendments have been passed and in 1969, 267 million dollars were spent. The Hill-Burton Act was the reason for thousands of hospitals to be built across the country. There was little planning of need or bed occupancy rates. Every community wanted its own hospital and they sprang up like mushrooms across America's landscape. Along with the hospitals came the ancillary services usually asociated with hospitals, such as radiology services, lab services and surgical suites. Americans wanted to be hospitalized. After all, this was thought to represent the zenith of medical care. The insurance companies also recognized a desire for more medical care and persuaded employers to provide first dollar coverage. The federal government passed Medicare in 1965, which was to provide medical care for that segment of the population over 65.

The public was inundated about regular medical check-ups, yearly chest x-rays, electrocardiograms and other assorted tests. Some employers even contracted with well known medical centers for their executives to have complete physical examinations on a yearly basis with upper gastrointestinal tests, barium enemas, gallbladder exams, pulmonary function and treadmill testing. All of these for largely asymptomatic patients with the only indication being a yearly exam. Medicare had few limits and paid on the basis of how long a patient stayed in the hospital and how many tests he had. People flooded to the hospitals for tests and physical exams as most health policies covered only inpatient care. This was an attempt, the insurance companies would later say, to save money by doing away with unnecessary tests which was felt to be done only as an outpatient. Patients and physicians, unfortunately, rapidly outwitted the health companies with hospital admissions solely for test purposes. This went on for three decades and served two purposes. It showed that the health care planners, insurance companies and Medicare were uneducable as to what was happening. If they did see what was happening, it was well disguised. There was very little planning either for the present or for the future. America seemed to be caught up in a ride to infinity on the health care train. The second purpose was to implant in the mind of the public that revenues for health care were limitless and indeed were to be used as quickly as possible. The government furthered this blind march as it inaugurated the renal dialysis program against criticism that future spending would far outstrip the money available. The amount of money spent for health care was on an upward spiral with no end in sight. In 1950, 4.6% of the gross national product was spent for health care. By 1975, this had risen to 8.3% and represented $547 for every person in the United States.

As the desire for more medical care continued, the federal government poured millions of dollars into medical schools to provide more doctors, to do research for new products and technological advances. Out of this would come, almost daily, new products with heart catheterization, CAT scans, new class of antibiotics, coronary artery bypass, liver, kidney and heart transplantation and other innovations.

Suddenly, by the mid 1970's the high cost of medical care was becoming apparent to the consumers, insurance companies and finally the federal government. At this time the demedicalization began. Many of the things which have been im-

printed on the nation's psyche were now pronounced as being wrong. The yearly physical exam, chest x-ray, electrocardiogram all came under question as being "cost ineffective." Medicare inaugurated DRGs, a system of prospective payment to cut down hospital costs. Insurance companies quit providing first dollar coverage, mandated second opinions and increased deductibles. All of these were designed to cut down the utilization of medical care.

Unfortunately, the same lack of planning which characterized medicalization also is prevalent in the demedicalization process. As we demedicalize, we also include those items which were found to be cost ineffective. Is there any rationalization for the refusal of Medicare to reimburse the flu vaccine when all evidence points to the savings in millions of dollars for avoided cost and disability benefits for some of the patient population? Surely, the evidence has been adequately presented for the savings of money and lives for performing annual mammograms in women over 50. Yet, Medicare does not recognize this as a legitimate reimbursable item. The Pap smear is another test which has saved thousands of lives performed on a regular basis, but is also not reimbursable unless there is a specific diagnosis.

Recently, Medicare has cut reimbursement for home care. This comes on the heels of DRGs. Supposedly, the whole concept of DRGs was to get people treated on an outpatient basis as quickly as possible. The saving grace of DRGs was that there would be many types of treatment which could be provided by nursing care providers. However, the federal government in its infinite wisdom has decided to trim this aspect of Medicare and now people who are discharged early and who need home nursing care will have some of this service stripped from them.

For any thinking person, there is no argument that many of the tests, which we as physicians ordered, and a great deal of the hospitalization that we did, were unnecessary. We cannot escape from this fact, nor can we avoid responsibility for our part in the events that led to demedicalization. However, other entities, most notably the federal government, will have to take some of the responsibility for being involved in a process which seems doomed to repeat many of the same mistakes which was done as we rushed to medicalize America. By not taking into account what went wrong when we medicalized America, we are surely going to repeat the same mistakes and I fear we are going to end up with a product, after the demedicalization has been completed to the satisfaction of the federal government, that is lacking in both adequate medical care and financial savings. It took 30 years to medicalize America and we appear destined to demedicalize in one third of the time. If the same mistakes are made in the process then that means that we will probably have three times as many mistakes and will end up with a product that has three times as many shortcomings as what we had less than five years ago. Yet, the federal government will have achieved its purpose in demedicalizing America and we as physicians and the consuming public will be the recipients of these results.

H. Frank Farmer Jr., M.D., Ph.D.
Historical Editor
New Smyrna Beach

It's time to start

As the summer draws to a close there has been time to relax a little this year to enjoy the experience of relief at having at long last obtained a reasonable malpractice reform bill from the state legislature. Before the 1985 session started, there were rumours circulating widely that this would be a "do-nothing" legislature where malpractice was concerned. A state-wide task force was preparing its report. Physicians were unusually charged with political activism after having ridden the emotional roller coaster of excitement over the promised campaign for Amendment 9 followed by discouragement and cynicism when the measure was thrown out by the Supreme Court. The public had finally begun to have an interest in the malpractice crisis and to understand that it had begun to effect their medical care. And despite all that pressure, many of those who were supposed to "know about such things" thought that the legislature would again pronounce the malpractice crisis to be a figment of doctors' imaginations and do nothing.

It came as something of a surprise then when real progress did come. The bill that passed was not perfect. In fact it fell far short on several important issues. But it was a step — a large step — in the right direction. The House finally admitted that there was a problem, and they took significant action to address that problem.

As Fall approaches it's now time to start to build on last year's victories. Now is the time to start to work on the upcoming legislative session so that more can be done. We sometimes lose sight of the fact that many of our legislators really don't understand our problems. Now, while there is more time to sit and talk with them at length, we have the chance to help them understand. Some of our legis-

lators don't really care about our problems because they don't think most of their constituents care. Now is the time for us to marshal and increase public interest so those legislators may learn to care. Some of our legislators are actively hostile to our aims. Now is a good time to let them understand clearly that we intend to put them in a position of having to defend their hostility if they can.

How do we go about accomplishing all this? Any way that works. Those of us who know a legislator personally should arrange a time to talk with him — not to him but with him. Let him express his doubts or prejudices and let him know yours. If he understands your position better he may support it more effectively. At the very least he will recognize your urgent telegraph on the eve of a big vote as part of a consistent position. It must make legislators feel pretty cynical when large organized groups seem to discover Tallahassee only when some major bill is beyond the point of allowing much chance for allowing much chance for change.

In addition, we must continue to involve our patients and fellow citizens in the campaign. Joint and several liability may seem sensible to trial lawyers but it strikes everybody else as unfair. The average citizen is against it. Most people aren't so sure about the advisability of putting a cap on general damages until they understand that the money has to ultimately come from the pockets of paying patients. This sort of information deserves continued public attention.

As the Summer draws to a close, it is time to put behind us the achievements of the last year and begin to work in earnest toward the further achievements of the next.

Henry L. Harrell Jr., M.D.
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Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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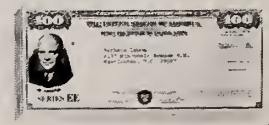

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CPI an unfair indicator of physicians' charges

Dear Editor: I read the article in the June 1985 edition, page 454, entitled "Are Charges Too High" written by Henry L. Harrell Jr., M.D., from the Marion County Medical Society. I find the article totally misleading and an injustice to many of the physicians that he might be accusing. What Dr. Harrell does not take into account are the five-year freeze on medical fees imposed by President Nixon, the present Medicare freeze on physicians' fees, the means by which medical fees are calculated under the Medicare system, and the high costs of medical vendor goods which far outpace the consumer price index.

Of these numerous vendor goods, malpractice is only one and it is quite obvious as to how the escalating cost in malpractice premiums has far outpaced the consumer price index which he quotes. Several years ago, silver skyrocketed in price and x-ray films went up 186% which was far higher than the consumer price index of that year. Silver has fallen in price; however, the cost of x-ray films has not.

I wish I could say that malpractice premiums for high risk groups, especially in Dade and Broward counties, have only increased on the same percentage basis as the consumer price index, but I can't. It is obvious to all of us that malpractice insurance premiums increase, on an annual basis, much more than the consumer price index percentages and, in turn, like any other business, these increased costs are being passed off to the consumer.

In many cases, doctors are still playing catch-up on their fees, thanks to President Nixon, and are also trying to compensate for the financial losses that they are taking from Medicare, Medicaid and Worker's Compensation by increasing their fees to the private patients.

Dr. Harrell is wrong in simplifying the rise in costs of physicians' services by simply comparing it to the consumer price index without any explanation. As in any average, there are highs and lows to reach that mean. Vendor costs to physicians are on the high side of the curve. His simplification of these facts is unfair to those physicians he is indicting.

Richard L. Glatzer, M.D.
Miami

Reply: Dr. Glatzer's points are well taken, and I hope that my article indicated that I agree with him that most physicians are trying to do the best they can in a bad situation. My point was that the situation is made worse for all of us when a few colleagues gouge the system. Apparently others share this concern, since this article evoked more positive comments from my colleagues than any other that I have written in seven years of monthly editorials for our county bulletin.

Henry L. Harrell Jr., M.D.
Associate Editor
Ocala

HMOs provide good care for less money

Dear Editor: It is heartening to read a reasonably scholarly article assessing the virtues or drawbacks of health maintenance organizations ("The Health Maintenance Organization as a Cost Containment Instrument: Logic or Illusion?" Jacques R. Caldwell, M.D., July, 1985, *The Journal of the Florida Medical Association, Inc.*).

Dr. Caldwell concedes that HMOs reduced the costs of health care. This has been documented in virtually every study on the issue. However, Dr. Caldwell's assertion that costs are lower because HMOs attract "the medically well manicured" patients who are healthier and incur less expenses than the populations seeking fee-for-service care is not reflected in the literature. Dr. Caldwell refers to the Rand Corporation's study published in the New England Journal of Medicine which confirms the cost containment attributes of a pre-paid group practice. He neglects to point out that the authors carefully excluded any selection bias in the design of this study. "Because of our experimental design, we can virtually rule out population characteristics as an explanation of the lower hospitalization rate at GHC. We conclude that GHC physicians were simply practicing a different style of medicine from that of fee-for-service physicians. We found no appreciable difference in use between the GHC experimental and control groups, suggesting that there was no risk selection in this case."[1] Common sense and experience in fact suggest that the opposite is true, that high risk patients will select an HMO and subject the organization to the risk of adverse selection. Will a patient with multiple medical problems who anticipates substantial service requirements join an indeminity insurance plan with 80% coverage, or an HMO with 100% coverage where out-of-pocket costs are likely to be nil?

Dr. Caldwell also concedes that there is no evidence to suggest that HMOs practice low-quality care. However, once again, he speculates that this reflects only the healthy populations that are served by HMOs. On the contrary, the Johns Hopkins analysis to which he refers evaluated 27 studies which were strictly controlled for selection biases. Matched groups of both HMO members and fee-for-service members were compared. "Of a total of 27 separate studies, 19 found that the general quality of health care, as indicated by the measures applied, was superior in the HMOs studied to that in general fee-for-service or other settings. In eight of the studies, either the quality of care was found to be similar in both settings, or the total study findings were inconclusive. None of these studies reported HMO care to be inferior overall."[2]

Dr. Caldwell states that "HMOs do not answer the problems of the high cost for the elderly or for the terminally ill or for the chronically ill or for the medically indigent, since HMOs do not serve these people." The Medicare population is clearly taking up HMO membership in increasing numbers. Many states have contracted with HMOs to provide care for their Medicaid populations, and have found the cost-containment effects to be comparable to what has been evident in the non-indigent population. The Health Care Financing Administration is realizing substantial savings by encouraging Medicare members to join HMOs under the new risk contracts. With respect to quality of care, the Johns Hopkins analysis concludes that "of particular significance to the field of public health is the persistent finding that quality of care, as measured by a range in indicators, is better for the poor and those with apparent high need in the facility-based HMO setting compared with that delivered to comparable populations in non-HMO settings."[2]

Those physicians associated with HMOs appreciate Dr. Caldwell's reassurance that HMOs are "not inherently wicked or unethical." However, his emphasis on financial motivations as the sole deciding factor for HMO affiliation excludes many other considerations. Physicians may join HMOs in order to practice medicine free of business and financial concerns, not the least of which is the need to generate services in order to achieve increased revenue. Security, enhanced personal lifestyles because of sharing of coverage, professional satisfaction, ample education benefits, and group interaction and stimulation are other key factors for HMO affiliation.

Finally, Dr. Caldwell's interpretation of the recent Louis Harris "report card" on HMOs, sponsored by the Kaiser Foundation, is highly selective. In fact, the report states that "more than eight in ten executives in companies offering HMOs report positive experiences with pre-paid plans. Over three times as many executives report that HMO membership has decreased costs to their companies as report it has increased costs (30% as compared with 8%). Incidentally, the Louis Harris survey also has the following statement with respect to the experience and satisfaction of HMO members: "HMO members are more satisfied with their health care services, plan coverage, and costs than our comparable non-members. The greatest difference between members and non-members is in satisfaction with the cost of health care services, but members also tend to be more satisfied with access to care. Overall, 48% of HMO members, 34% of eligible non-members, and 36% of the public quote they are "very satisfied" with the health care services they have used recently."[3]

While the HMO is not the panacea for all the ills of the medical delivery system, neither is it an experiment or a fraud perpetrated on the unsuspecting public. HMOs have existed in the U.S. since 1938, and currently carry 15,000,000 subscribers. They clearly provide care of acceptable quality in a cost-effective manner that generates a high degree of acceptance among both members and employers.

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Jacob Lazarovic, M.D., F.A.A.F.P.
Plantation

Heading for the last round down

Dear Editor: The U.S. Public Health Service (PHS) has sent me a notice in regard to some financial dealings that we enjoy, saying that in our future transactions any final dollar amount I receive will be subject to round down. It explains that any uneven amount representing my pennies will be rounded down to the nearest dollar, before I receive my just reward.

The round down policy is new. It is at variance with my annual tryst with the Internal Revenue Service (IRS) which asks me to round off. When I round off any of 49 possibilities between one and forty-nine cents, I can pay the IRS less, i.e. the lower round dollar value. For any of the 50 possibilities between fifty cents and ninety-nine cents, I must pay more, i.e. increase to the amount of the next dollar.

In that IRS battle the odds are then 50 to 49 in favor of the government. Not too bad. However, with the round down, the PHS will always use a lower dollar value. The odds are now 99 to 1 in favor of the government.

Webster's Second Unabridged says that to round off is to reduce indicated accuracy, and it gives also a happy medical meaning for round out, which is to "regain the plumpness of health." It tells us that round up is the gathering of scattered persons or things, such as (U.S. West) cattle. However, Webster is very specific that round down is not what the PHS says it is. It is a nautical term which should interest the PHS since it was founded to care for America's merchant seamen. It means "to haul down on (a tackle) so as to lower the lower block." To a landlubber, that double lower doesn't mean much, but to an accountant in this Republican administration, it must have been an inspiration.

So someone in the PHS has created a new meaning for round down. Surprisingly, it is not too far from Webster's square up, which means to "settle accounts, to pay off." Perhaps the medical profession is the first to square up with the round down. I expect that the disease will spread and that the IRS will apply it to most people, including those who have not yet rounded out, i.e. to patients as well as to doctors. Then despite the ugly use of the two d's in juxtaposition, the round down, or even the round-down or roundown, will mean that everyone must pay up from now to the last round up.

Paul J. Schmidt, M.D.
Tampa

Why the double standards?

Dear Editor: I was absolutely shocked to read that Governor Graham had signed legislation allowing physicians from the Mayo Clinic to practice medicine at their new facility in Jacksonville without the benefit or privilege of a Florida license obtained in the same manner as any other physician now practicing.

Few would doubt the competency and excellence of the physicians of Mayo and the reputation of that Minnesota institution. Clearly, the legislative intent must have been to facilitate Floridians' access to a Mayo branch in Florida. But with the simple stroke of the pen, there is created a double standard of practicing physicians: those licensed by Florida through examination by the State of Florida, FLEX, or National Board of Medical Examiners, and those who practice by mandate of the authority of the Governor's fiat. This edict effectively emasculates the medical licensing board by diminishing its scope of authority and undermining its responsibility in determining the qualifications of practicing physicians, and in providing Florida with qualified medical practitioners and in disciplining those who fail to maintain standards, a vital key to the control of malpractice in our state.

These physicians, however fine, still must answer to the State of Florida and its licensing authority to practice medicine here. The State of Florida simply cannot allow two standards of qualifications for medical practice in our state.

John W. Morris, M.D.
Daytona Beach

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President's Address
Frank C. Coleman, M.D.

Mr. Speaker, members of the House of Delegates and guests, just a year ago, I stood before you as your newly installed President, and in my brief remarks at that time, I called for unity and participation in a time of great change. I suggested that our obligation as physicians, as it always has been, is to provide quality medical care regardless of the changing times. I indicated that the theme of my administration would be: One Profession — One Association — One Future.

As one profession, no matter what specialty we are, no matter what our mode of practice, we are all physicians first. We must work to further the best interests of that profession, knowing that none of us can succeed unless the profession succeeds.

We are one association. The state association, in cooperation with all the county medical societies and the specialty organizations, must have unity and represent all physicians. It must have programs, projects, policies and philosophy that meet the needs and further the goals of all physicians, regardless of their individual attributes and circumstances.

We all have one future. What happens to one of us happens to all of us. Some physicians cannot succeed while others fail. We all succeed together as physicians, or we all fail. Whatever differences exist, our response to problems of the future — be they legislative, economic, professional or scientific — must be focused toward the needs of all.

Since that day a year ago, the changes of which I spoke have occurred with a rapidity and magnitude that far exceeded what I had believed possible.

An article in the *Wall Street Journal* on March 18 contains a quote which provides at least a partial explanation. This article, entitled "More Firms Are Telling Workers Which Doctors They Should Use," contains the following statement:

> "The U.S. health-care system is in the throes of a revolution," says Jeff Goldsmith, a health-policy consultant to Ernst & Whinney, the accounting firm. "Power so carefully accumulated for almost five decades is shifting from those who provide care to those who pay for it."

Those of you who attended our Leadership Conference in February heard Paul Starr, the author of *The Social Transformation of American Medicine*, describe how this change is occurring.

Frank C. Coleman, M.D., FMA President

I can report to you that my administration as your President has been a very active one. The action began on May 7, 1984, one day after my installation, when representatives of the Commissioner of Insurance, armed with a court order, served notice on our Florida Insurance Reciprocal that the Reciprocal had 30 days in which to indicate that it could meet the reserve requirements of the Florida Insurance Code. The Insurance Department had, in effect, taken over the management of the Reciprocal.

The Florida Medical Association reacted promptly by first identifying the problems of the Reciprocal and, second, looking for solutions to these problems. After many, many meetings that involved the Insurance Commissioner, representatives of the American Medical Association, other insurance carriers, and the FMA, an agreement was worked out with the Physicians Insurance Company of Ohio (PICO) for it to take over the Reciprocal. This occurred on January 3, 1985. The Reciprocal is now operating in a sound and effective manner.

During these months of negotiation, a great deal of misinformation about the troubles of the Reciprocal was circulating. Detailed investigations of the Reciprocal were made by the American Medical Association, the Insurance Commissioner's staff, and PICO. None of these investigations turned up evidence of criminal or fraudulent behavior on the part of those involved in the previous management of the Reciprocal. Reports on these investigations did raise questions about management decisions, including investment policy and rate structure. Because of continuing concerns expressed by the members, last fall the Florida Medical Association retained the national auditing and consulting firm of Ernst & Whinney to make a detailed audit of the Reciprocal. The Ernst & Whinney report reached the same conclusions as those reached in the other investigations. A copy of this Ernst & Whinney report was sent to every member of the Florida Medical Association for review.

I would suggest to you that the time has come to put the old Reciprocal problems behind us and concentrate on the problems of the present and of the future. PIMCO, the company that previously handled the management functions of the Reciprocal, has been dissolved and no longer exists, so there are no vestiges of the past linked to the new rehabilitated Reciprocal.

I would now like to discuss the most serious problem facing physicians in Florida at the present time. The problem is that of the medical malpractice insurance crisis. Those of you who have been practicing for more than a decade remember the previous crisis of 1975 when the Argonaut Company precipitously withdrew from the Florida market, leaving the majority of physicians in our state uncovered for liability insurance. The problem was brought promptly to the attention of the Legislature by the Florida Medical Association. The Legislature responded by enacting several statutes. These included: an enabling act for a physician-owned insurance company, which became the Florida Physicians Insurance Reciprocal; a patient's compensation fund; and a mediation panel system.

That crisis stabilized rather quickly, and for several years premiums were almost level and claims were stable although there was some increase in the size of awards. In 1980, however, the Florida Supreme Court, in response to the third effort of the Florida Academy of Trial Lawyers, declared the mediation panel law to be unconstitutional.

Almost immediately, claims quickly increased in number and the size of awards sharply increased. In 1984, Florida, although seventh in size, ranked third of all the states in the number of awards, and first in the size of awards. The Florida Medical Association reacted to this rapidly developing crisis by going to the Florida Legislature in 1983 with a Legislative Program which would have provided relief. We were successful in the Senate but could get no action in the House of Representatives. The Speaker of the House was a trial lawyer who adamantly refused to let the bill up for consideration on the floor. In 1984, another effort was made with the same result, since the cast of characters was still the same.

In anticipation of this result, by unanimous vote of the House of Delegates, a decision was reached in January 1984 to take the issue to the people in the form of a constitutional amendment to be funded by a mandatory assessment. Constitutional initiatives in Florida must adhere to rather rigid requirements in order to qualify for the ballot, which include obtaining a large number of petitions. In 1984, approximately 300,000 signatures were required. After the petition had been drafted, a campaign to obtain the required signatures was begun. Support of this petition drive by physicians was excellent in some parts of the state and not so good in others. In order to meet the required deadline to get the petition on the ballot, it was necessary to retain a firm specializing in this field. The petition drive was successful in that more than 600,000 signatures was obtained.

After validation of signatures, the amendment was certified for the November 6 ballot. Shortly thereafter, the Florida Academy of Trial Lawyers filed a lawsuit in an effort to get the amendment off the ballot. This lawsuit was first tried in the circuit court in Tallahassee. Judge Ben Willis, who heard the case, promptly ruled in favor of the Florida Medical Association. The trial lawyers then appealed to the Florida Supreme Court.

In spite of the prompt and favorable ruling by Judge Ben Willis, however, the Florida Supreme Court rather precipitously, and in what I believe was

largely a political rather than a legal decision, ruled that our amendment did not meet Constitutional requirements and struck it from the ballot. This decision was based on reasoning that first appeared when Proposition One was stricken from the ballot. This reasoning was vastly different than that which had been followed with respect to previous amendments, such as the gambling amendment of several years ago.

At the time the Constitutional Amendment was approved by the House of Delegates, an active educational program was launched by the Florida Medical Association to provide public understanding of the seriousness of the medical malpractice crisis and of the implications for every citizen of our state. The Florida Academy of Trial Lawyers reacted with a public relations campaign of their own which was about as scurrilous as any that I have ever seen. We had anticipated this attack and had prepared appropriate responses that were to be used during the last two or three weeks of our campaign.

Coming right on the heels of the Reciprocal's troubles, this demise of Amendment 9 increased the concerns of many of our members. That is understandable, for we still have the medical malpractice crisis with us. Amendment 9, however, was a very productive effort for the Florida Medical Association. For the first time, we were able to develop enough understanding on the part of the public that there is a problem, that it is serious, and that it is costing the people of Florida a great deal more for health care than in necessary, and that it is interfering with both quality and access to health care.

The old cliché of the Florida Academy of Trial Lawyers that there really would not be a problem if the doctors would clean up their own act and get rid of the "bad doctors" and, further, that there is no economic problem here because liability insurance premiums represent only 2½% of a doctor's income is no longer blindly accepted. Neither of those statements is true, but as is frequently the case, repetition leads to acceptance on the part of many people.

Last fall, the six business coalitions for health in Florida set up a task force on medical malpractice. These coalitions are composed primarily of businessmen who are concerned about the cost of health programs for their employees and their dependents. This task force was composed of representatives of major businesses and industry. The task force held hearings throughout the state and many witnesses were given the opportunity to present their views on medical malpractice problems. I testified on behalf of the Florida Medical Association.

This business coalition task force has finished its work and has prepared a report which contains some important recommendations. These include: The strengthening of the Board of Medical Examiners' ability to ensure that foreign medical graduates have adequate medical training; mandating professional liablity insurance coverage for all physicians in the minimum amount of $150,000 per claim and $450,000 per year; mandating 12 hours of continuing education during the previous 24 months and an additional 3 hours of continuing education in the area of risk management; expanding the entities required to report disciplinary action against physician staff members to include health maintenance organizations and ambulatory surgical centers; eliminating the doctrine of joint and several liability; mandating the establishment of internal risk management programs in all hospitals; changing the standards of proof in medical malpractice actions from "the greater weight of the evidence" to "clear and convincing evidence"; requiring that medical experts in medical malpractice cases must have been engaged in the practice or teaching of medicine within the 24-month period preceding the alleged act of malpractice; and placing a limit of $500,000 on non-economic damages (excluding punitive damages) in any medical malpractice case.

In addition, the task force is recommending to the Legislature that it study an appropriate limit to be placed upon contingency fees or, in the alternative, that the Legislature adopt an appropriate resolution to the Supreme Court, requesting that the court impose such a limitation. These recommendations have been converted into Legislative language and will be considered by the Legislature.

Late in the 1984 Legislative Session, Senator Dempsey Barron introduced an alternative proposal to deal with the medical malpractice problem. His proposal would remove medical malpractice from the tort system and place it in a new system which would resemble in many respects the no-fault automobile insurance and the workers compensation programs. Because there was inadequate time for the Legislature to consider this proposal, the Legislature appropriated $200,000 to finance a Governor's Task Force on Medical Malpractice and requested the Governor to appoint such a task force.

The Governor did appoint this task force and it met for several months. It had a larger membership than that of the business coalition task force and did include three physicians who served with distinction on the task force. This task force concentrated on alternative approaches in the belief that it would be difficult, if not impossible, to solve the medical malpractice crisis by changes in the tort system. This task force completed its work on April 1 and submitted its recommendations to the Governor.

Senator Dempsey Barron, Chairman of the Medical Malpractice Committee in the Senate, has introduced, along with 13 co-sponsors, his revised bill for an alternative, non-tort system for resolution of medical malpractice claims, Senate Bill 1030.

The basic element of the Legislation is to preserve the threshold issue (breach of standard of care), but it is settled by a judge rather than a jury. It proposes that the case be approached as one in contract rather than in tort. But once the obligation to pay damages has been established, this proposal is much more predictable and forthright than the current system.

First, the bill provides for reimbursement for all necessary and customary medical expenses. It also provides for rehabilitation benefits. All of this is designed to heal the person who is injured and to minimize the effects of the medical incident. If the medical incident causes disability that lasts more than seven days, there are specified temporary benefits and specified permanent benefits that are objective and that can be calculated upfront because they are based on the earning history of the injured person. They relate directly to the economic loss resulting from the medical incident. They are designed to replace everything that was lost.

In addition, there are impairment benefits that can be as high as $100,000. These benefits are based upon a determination of the degree of disability the permanent injury causes to the plaintiff. Finally, if death results, there are specific, identifiable death benefits for those who were dependent upon the deceased. There is no provision in the bill for general or non-economic damages.

A person who is the victim of a medical incident would be much better off under the proposal than under the present tort system. If the right to damages was established, he would not have to roll the dice to see whether he would be undercompensated or overly compensated. He would not have to share his award with his attorney (attorney's fees are in addition to the award) and the benefits would be paid forthwith. Moreover, the benefits would be designed to fairly compensate the injured person for the adverse effects of the incident for so long as those adverse effects persist.

It is anticipated that SB 1030 will be agendaed shortly for consideration by the Senate Select Committee on Tort Reform. FMA has been working with Senator Barron to refine the bill and address the technical problems. It is anticipated that this bill along with a bill introduced by Senator Mattox Hair (D-Jacksonville) will be among the key pieces of Legislation dealing with malpractice moving through the Senate.

On April 4, the Chairman of the Special Subcommittee of the House of Representatives on Medical Malpractice, Representative Art Simon, called a press conference to announce the Committee's recommendations for solving the problems related to the malpractice crisis. These recommendations are far-reaching. As Chairman Simon said at the press conference: "The proposed committee bill seeks to accomplish three important objectives: first, prevention of incidents of medical negligence; second, prompt resolution of legitimate claims; and third, affordable liability insurance for all health care providers."

This committee bill, PCB 85-2, known as the Comprehensive Medical Malpractice Reform Act of 1985, is a very complex bill containing 43 recommendations.

Some of these original recommendations are favorable to our position on tort reform, but others are unacceptable.

The positive points include:

1. There are numerous sections that provide additional authority for the Board of Medical Examiners. It is felt this authority is needed to better police the so-called "bad doctor."

2. There is a provision that will provide for agreements to arbitrate under certain HMO and PPO health care contracts. This is a step in the direction of allowing private parties to establish the boundaries under which they will resolve disputes arising over health care delivery.

3. There is a provision in the bill that will allow insurers to offer to groups of physicians medical malpractice insurance on a group written basis. This has heretofore been prohibited under Florida law.

4. The bill addresses the definition of medical negligence and amends the current law to take into consideration the "prevailing standard" of care that is being provided in the community by different health care delivery mechanisms.

5. The bill establishes a sliding scale of contingent fees in medical malpractice cases which will assure that injured parties who receive compensation will in fact be able to obtain a greater portion of the award than they are now able to under the existing contingency fee scheme employed by most attorneys.

6. The bill provides a requirement that attorneys investigate the circumstances and certify that a good faith belief exists prior to filing a medical malpractice action.

7. The bill creates a certification provision for the certification of foreign medical educational institutions.

We have offered constructive amendments on those recommendations that are of concern to us and will continue to press for their adoption. These include:

1. Reducing the threshold for structured settlements to $500,000.

2. Providing an opportunity for a defendant, within a 90-day period following notice of a claim, to offer to pay the claimant's net economic loss, consisting of medical expenses and lost wages, and to pay the claimant's attorney a reasonable fee.

The claimant would be obligated to accept this offer if made within the 90-day period. Penalties would be included to encourage a defendant to make such an offer if one was warranted.

3. Substituting stronger language for elimination of joint and several liability such as included in the Bell Bill, H.B. 622.

4. Amending the requirement for mandatory continuing education by the State Board of Medical Examiners to recognize enrollment in similar programs, such as that of the Florida Medical Association or the American Medical Association.

5. Striking from the bill several of the recommendations, including the liability of health care facilities for the negligent acts of their medical staffs; a special risk category with a premium cap on rates paid by physicians, funded by a 10% assessment against premiums paid by physicians; that section dealing with unnecessary diagnostic testing; and the mandated million dollars coverage per claim with a $3 million aggregate.

Some provisions of the Simon Bill are being violently opposed by the Florida Academy of Trial Lawyers. At the first hearing on the Bill, the trial lawyers were successful in getting the Simon Subcommitte to strike from the Bill the sections dealing with contingency fees and prevailing standards of care.

Some of our recommendations were adopted, including reducing the threshold for structured settlements to $500,000.

We are prepared for very aggressive efforts to restore the stricken sections on contingency fees and standards of care and to gain acceptance of our recommendations when the report of the Simon Subcommittee is considered by the full Committee on Health Care and Insurance and later on the floor of the House when it takes up this Bill.

All the resources of the FMA will be involved in this effort. The outcome cannot be predicted at the time this report is being prepared for you. You will be kept informed, however, of the progress of this Bill, as well as that of the Barron Bill in the Senate.

Whether the Legislature is going to come up with an adequate solution this year or not remains to be seen as the Legislature will be in session for another four weeks. Our position is much stronger than it has been in previous years. We have more understanding on the part of the public; we have more allies in this effort. We have been able to point out that if this problem is not solved quickly, the impact upon costs of health care, access to health care and quality of health care will be severe.

To facilitate public understanding, I have met with many groups, including representatives of the American Association of Retired Persons, associated industries, insurance agents of Florida, leadership of both the House and the Senate, the Governor on more than one occasion, the Insurance Commissioner, and representatives of several other professional groups. In addition, I have met with the editorial boards of the urban newspapers in Florida for a detailed discussion of the problem.

Several months ago the Florida Medical Association entered into an agreement with Dr. Henry Manne, Director of the Law and Economic Center at Emory University, Project Director for carrying out an extensive research project on medical malpractice. We have just received Dr. Manne's report. This is a voluminous report which he has called a medical malpractice guidebook. This guidebook covers every major topic in the area of malpractice.

Various sections of the guidebook were authored by nationally known experts in the field of law and economics as they relate to medical malpractice.

We believe that meaningful reform in the medical malpractice area is impossible without an accurate assessment of where we are presently. Accordingly the guidebook addresses the following aspects of the medical malpractice issue:

1. Statutory efforts and their economic effects, both in Florida and other states.

2. The present state of Florida malpractice law, both statutory and case law.

3. Economic consequences of Florida law with respect to damages for pain and suffering.

4. The law and economics of Florida Insurance Regulation.

5. The various remedial approaches that have been proposed and can be considered in the future.

We also believe that this guidebook will be helpful to everyone concerned about the malpractice dilemma and how to address the correct issues. Furthermore, we have been concerned that we ought not have anymore false starts made in this field or the adoption of proposals that would really not serve the interest of the citizens of Florida. We believe that the guidebook represents the most comprehensive collection of current knowledge there is today. We are hopeful that this work will lend itself to an informed and dispassionate debate on the topic so that ultimately Florida may achieve the best possible means for dealing with the malpractice crisis.

I would suggest to you as members of the House of Delegates that if our efforts, aggressive as they are, are unsuccessful in 1985, we must seriously consider going back to the people again in 1986 with another Constitutional Amendment. We will be much better prepared than we were in 1984 in that we have a great deal more information about the problem and its impact, more understanding of those elements that will result in improvement, and a clear indication that the Legislature is either unwilling or incapable of dealing with the problem.

Dr. Martin Halley, a cardiovascular surgeon in Topeka, Kansas, recently pointed out the complexity of the medical malpractice problem in an article published in *The Journal of the Kansas Medical Society*. I quote:

> It is not a problem of substandard health care practices that can be solved entirely through risk management or disciplinary action against physicians; it is not primarily a controversy between physicians and trial lawyers or between health care providers generally and the legal profession, although this has been suggested over and over by the media; it is not primarily a problem of the insurance industry manifested by rising premiums; nor is it a problem of the makeup of the State Legislature or the State Regulatory Agencies.
>
> It is a problem of either personal injury, or possibilities of personal injury, to patients in this high technology modern health care system in which we live. An astronomical number of decisions and individual judgments for either delivery or non-delivery of care must be made on every patient. Not every patient has a result that is optimal or is what was hoped for by the patient.
>
> The problem is ultimately one of society. There is a very close analogy between what we are now seeing in medical malpractice and the industrial injuries that began to occur as part of the Industrial Revolution. We live in a litigious society where the phenomenon of increasing malpractice claims and awards is occurring while health care delivery has attained heights of success previously unimaginable and where great scientific and technological advances continue. This phenomenon is not limited to health care, but is only one segment of personal injury litigation that is prevalent in the United States today, such as that involving automobile liability, product liability, air and rail liability, homeowner liability and professional liability generally.

We are also living in a society where we have an increasing number of highly skilled and increasingly specialized attorneys who work within the framework of a distorted contingency fee system. There is increased emphasis in law school curricula on medical malpractice, and there is an unquenched thirst of the news media for publicity on all kinds of medical affairs. The influence of greed, both on the part of the trial lawyers and on the part of the public because of the increasing large awards, judgments and settlements leads to more and more lawsuits.

Our entire Legislative program for 1985 is described clearly in the report and the supplemental report of the Council on Legislation. I direct your attention to these reports.

Although preoccupied a good part of the year with the medical malpractice problem, we have been active in other endeavors.

Our efforts to obtain the PRO contract were unsuccessful as you know, just as was the case with most state medical societies. This was due to the differences in the goals of the government and those of physicians. The government placed emphasis on cost saving whereas physicians were concerned about the quality of health care. The objectives in our proposal were therefore not acceptable to the government. Many complaints about the PRO program have occurred, both in Florida and elsewhere. Recognizing deficiencies in the program, the health care financing administration is now in the process of establishing a super PRO to evaluate the 52 PRO programs that are in operation to determine what changes should be made.

The FMA filed an appeal following the awarding of the contract for the PRO and vigorously pursued this appeal. We also submitted a resolution to the AMA in December 1984, expressing our concern about PRO and asking the AMA to take whatever steps are available to make the program more acceptable. Our appeal was recently rejected.

Early in my administration, I appointed several new committees. One of these was a committee on

programs and priorities. Under the Bylaws of the FMA, the Executive Committee of the Board of Governors is charged with the responsibility of long-range planning. Because of the multiple problems with which the Executive Committee has been dealing in recent years, however, long-range planning has not received appropriate attention. This Programs and Priorities Committee was asked to review all activities of the FMA and to make recommendations to the Executive Committee for changes in our programs, including long-range planning.

You will be considering over the next four days a number of recommendations which came from this Programs and Priorities Committee and were approved by the Board of Governors for submission to you. These include:

1. Changing the Annual Meeting time of the Association from May to September so as to strengthen the ability of the Association to deal with our many legislative problems on a more timely basis.

2. Restructuring the Board of Governors so as to give the House of Delegates the authority to elect the four District members of the Board rather than having them appointed by the President.

3. Detailed financial reporting to the House on the finances of the Association.

4. Providing specialty society representation in the House of Delegates.

5. Better coordination with specialty societies, including staffing and Legislative activities.

6. Shortening the time of the Annual Meeting.

All of these recommendations are important in view of the problems that we face. I strongly support all of them and urge you to give them careful consideration.

Anticipated changes in physician reimbursement for Medicare patients and private patients, the development of HMOs and PPOs, the surplus of physicians, the heavy emphasis on cost containment with modest attention to quality of care, will cause many interspecialty and turf problems. Satisfactory solutions to these problems can only be found if all specialties in the profession have the opportunity to present their concerns and, by compromise and efforts at consensus, reach the unity that is so essential for our survival.

Another new committee appointed last year was that on health manpower. We are having increasing problems with allied health groups that want to enter, and in some instances pre-empt, segments of the practice of medicine. We must have a data base on the activities of these groups; we must have individuals to serve as witnesses before Legislative committees and as advisors to spokesmen for the Association. The list of allied health groups that are seeking licensure, mandated insurance coverage and hospital medical staff privileges is increasing and must be updated regularly.

A Council on Hospital Medical Staffs was authorized by this House last year. The Council is now fully organized with strong leadership and is hard at work with programs to deal with problems that are peculiar to hospital medical staffs. One of the first assignments given to this Council was that of promoting risk management programs within the medical staff structure in every hospital of this state. Active risk management programs are one way to help with the solution to the medical malpractice problem. I believe that a risk management program for physicians must be an integral part of the medical staff structure, with another risk management program operating under the jurisdiction of the hospital administration. There obviously has to be some cross fertilization of these two committees.

Physicians in Florida are very disturbed by what they perceive to be a changing attitude on the part of the public toward physicians. There is justification for this concern as recent studies have demonstrated that the status of the physician, although remaining high, is not as high as it used to be. A report from the group on public and federation relations of the American Medical Association was published in February of this year. Interviews, which formed the basis of the report, were conducted in November 1984 by the Houston-based firm of V. Lance Tarrance and Associates. This report indicates the following:

> Sixty-one percent of people believe that doctors do not spend enough time with their patients.
>
> Fifty-four percent believe that doctors do not care about people as much as they used to.
>
> Forty-eight percent believe that most men and women who become doctors today do not do so because they want to help other people, but for money and prestige.
>
> Only 28% believe that young men and women become doctors to help people, and only 25% believe that they enter medicine both for prestige and money and for helping people. This clearly indicates that many people believe that physicians are more motivated by money than they are by a desire to help people.

Those of us who have served on a county medical society grievance committee are well aware that the lack of good doctor-patient communication is responsible for many of the complaints against doctors and the changing attitude of the public toward doctors. The second most common cause has to do with fees because the patient thinks the doctor charges too much. Only a few complaints are registered with respect to the quality of care.

In an effort to change this trend, I support a coordinated public relations program which would involve the AMA, the FMA, and county medical societies. This is currently under discussion, but I believe that the best public relations is good communication between doctors and individual patients.

I have spent a lot of time this year in an effort to improve communication between the leadership of the FMA and the membership. Twenty Presidential memoranda have gone to each member of the Association. I have had the privilege of attending many of your county medical society and specialty society meetings. I have met in an open forum with the Presidents and Executives of the county medical societies. The Presidents and Executives of the county medical societies are now invited to attend meetings of the Board of Governors and are being given the opportunity to participate in the meetings.

As I bring this report to a close, I would like to quote from the report made by Dr. James H. Sammons, Executive Vice President of the American Medical Association, to the House of Delegates at its Interim Meeting last December. I quote:

> Nothing would please me more than to tell you that we are soon to enter upon a new era in which we will quickly solve all our problems, achieve all our goals and confound all our enemies. Unfortunately, we are a long way from finding a New Jerusalem, and I am afraid that we shall have to continue doing business where we are — in the real world.
>
> To be effective in the real world, to deal successfully with other institutions, to meet new public demands, to respond to changing societal needs, is not the simple matter some people think it is. When issues arise, they are generally resolved through a parliamentary process, a process characterized more by accommodation and compromise than by clear-cut victories and defeats. To operate successfully in this world requires understanding the art of the possible, generous measures of restraint and sophistication, plus patience and staying power.
>
> In periods of worry and frustration, such as we are experiencing now, it is often tempting to try the pat and simple solutions that are frequently offered, to consider changes that really have little relevance to the difficulties at hand. The usual result of such actions is the throwing out of babies with the bath water. Rather than yield to simplistic suggestions, it has usually been more effective policy, in my experience, to stay focused on our problems, to work for a wider understanding of our viewpoint, to develop allies to aid us in our causes and to seek modification of objectionable statutes or pursue their overturn in the courts.

I am in agreement with Dr. Sammons. There is no quick fix to our problems, but we must work together to achieve well-thought-out and effective solutions.

By giving me the opportunity of serving as your President this past year, you have permitted me to learn much about you and your concerns, and I want to thank you for the opportunity.

Serving as President of this organization, however, has now become for practical purposes a full-time job, and I see little change in the demands and responsibilities of the office for years to come. This is a matter that will require discussion both by you as the House of Delegates and by the Board of Governors.

Thank you again for the honor and privilege of having served as your President.

First House of Delegates

The First House of Delegates convened at 3:30 p.m. on Wednesday, May 1, 1985 in the Regency East/South Room of the Diplomat Hotel, Hollywood, Florida, with James B. Perry, M.D., Speaker of the House, presiding.

The House rose for the invocation which was given by Sanford A. Mullen, M.D., remained standing for the Pledge of Allegiance, and the singing of "The Star Spangled Banner" led by Mrs. Edie Epstein and played by Dr. Guy Selander.

Dr. Perry announced the membership of the Credentials Committee:

Thomas D. Bartley, M.D.
Gerald L. Stoker, M.D.
Richard I. Barr, M.D.
George E. McLain, M.D.

The Delegates were reminded that they must register with the Credentials Committee before this and every meeting of the House of Delegates.

Thomas D. Bartley, M.D., Chairman of the Credentials Committee, announced that 176 Delegates were present, representing 33 component societies, which constitutes a quorum.

A motion carried to seat the Delegates.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; Elayne E. Cassisi, M.D.; Richard M. Fry, M.D.; William T. Hawkins, M.D.; (Absent — Charles P. Gibbs, M.D.; D. Orvin Jenkins, M.D.; Michael Fagien, Student Delegate)

BAY — James T. Cook III, M.D. (Absent — B. Philip Cotton, M.D.; Terrence R. Steiner, M.D.)

BRADFORD — (Absent — Carlos M. Hernandez, M.D.)

BREVARD — John B. Adamson, M.D., Richard I. Barr, M.D.; Howard W. Pettengill, M.D.; Robert C. Ufferman, M.D.; (Absent — Raymond A. Armstrong, M.D.; Onofre P. Carrillo, M.D.; Ovid E. Vitas, M.D.)

BROWARD — Walter A. Campbell, M.D.; Andre S. Capi, M.D.; Phillip A. Caruso, M.D.; Thomas E. Corley, M.D.; David A. D'Alessandro, M.D.; George T. Edwards, M.D.; Ira Finegold, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; Theodore W. Hahn, M.D.; John M. Harper, M.D.; William C. Hartley, M.D.; Wayne R. Johnson, M.D.; David C. Lane, M.D.; George P. Messenger, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Ray E. Murphy Jr., M.D.; Richard D. Shafron, M.D.; Marvin L. Stein, M.D.; Arnold L. Tanis, M.D.; H. Murray Todd, M.D.; Alan J. Yesner, M.D.; (Absent — George J. Crane, M.D.; Arthur L. Eberly, M.D.; Joseph M. Sachs, M.D.; Ernest G. Sayfie, M.D.; Donald D. Sheffel, M.D.; Juan S. A. Wester, M.D.)

CAPITAL — Robert P. Johnson, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Terence P. McCoy, M.D.; Robert N. Webster, M.D.

CHARLOTTE — Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; Luis H. Serentill, M.D.

CITRUS — W. Randall Jenkins, M.D.; (Absent — Alexander E. Hlivko, M.D.)

CLAY — (Absent — Hinson L. Stephens, M.D.)

COLLIER — Charles S. Eytel, M.D.; Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.

COLUMBIA — (Absent — Nanjunda Swamy, M.D.)

DADE — Edward R. Annis, M.D.; Jerome Benson, M.D.; Pedro P. Bosch, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; Richard C. Clay, M.D.; Vincent P. Corso, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Norman T. Ditchek, M.D.; Charles A. Dunn, M.D.; Byron D. Epstein, M.D.; Miguel Figueroa, M.D.; Denio O. Fonseca, M.D.; Richard L. Glatzer, M.D.; Joseph Harris, M.D.; Donald E. Johnson, M.D.; Norman M. Kenyon, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Linda Maraccini, M.D.; Miguel A. Mora, M.D.; Dolores A. Morgan, M.D.; Sheldon D. Munach, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Manuel A. Porto-Sastre, M.D.; Pedro A. Ramos, M.D.; Jeffrey B. Raskin, M.D.; Harry T. Remmer, M.D.; A. Frederick Schild, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; Margaret C. S. Skinner, M.D.; Douglas Slavin, M.D.; Marvin B. Slotkin, M.D.; Samuel P. Stokley, M.D.; Charles F. Tate, M.D.; Emilio A. Trujillo, M.D.; Osvaldo D. Valdes, M.D.; Harold H. Weiner, M.D.; Steven M. Weissberg, M.D.; Leo Whitman, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; (Absent — Manuel Abella-Fernandez, M.D.; Carlos L. Abraira, M.D.; Harlan S. Chiron, M.D.; Jorge DeCardenas Jr., M.D., N. Ralph Frankel, M.D.; Antonio F. Frexes, M.D.; Maurice H. Laszlo, M.D.; William I. Roth, M.D.; Oscar Sandoval, M.D.; Claudio R. Villoch, M.D.; Ana Isabel Gonzalez, Student Delegate)

DESOTO-HARDEE-GLADES — Calvin W. Martin,M.D.

DUVAL — Gaston J. Acosta-Rua, M.D., Clyde M. Collins, M.D., James H. Corwin II, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Walter A. Harmon, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; Charles T. Montgomery, M.D.; John A. Rush, M.D.; Jack L. Sapolsky, M.D.; James W. Walker, M.D.; H. Warner Webb, M.D.; (Absent — Harvey E. Bernhardt, M.D.; William P. Booras, M.D.; John F. Lovejoy Jr., M.D.; Charles B. McIntosh, M.D.; Faris S. Monsour, M.D.; Daniel B. Nunn, M.D.; Robert H. Threlkel, M.D.; George S. Trotter, M.D.)

ESCAMBIA — Richard H. Ciordia, M.D.; Eric R. Geiger, M.D.; Charles J. Kahn, M.D.; Larry J. Sauls, M.D.; Robert K. Wilson Jr., M.D.; Henry M. Yonge, M.D.; (Absent — Michael R. Redmond, M.D.)

FLAGLER — John M. Canakaris, M.D.

FRANKLIN-GULF — Joseph P. Hendrix, M.D.

HERNANDO — Clinton J. McGrew Jr., M.D.

HIGHLANDS — Joseph A. Mitchell, M.D.; Luis M. Pena, M.D.

HILLSBOROUGH — Frank C. Coleman, M.D.; Richard G. Connar, M.D.; Thomas H. Griewe, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Ralph E. Rydell, M.D.; Stewart Siddall, M.D.; Gerald L. Stoker, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D. (Absent — Richard A. Bagby, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Richard S. Hodes, M.D.; Thomas E. McKell, M.D.; Ronald L. Seeley, M.D.; Harold L. Williamson, M.D.; T. Roland Reeves, Student Delegate)

INDIAN RIVER — Donald L. Ames, M.D.; Paul A. Graham, M.D.; Kip G. Kelso, M.D.

LAKE — Joseph A. Comfort, M.D.; (Absent — Joseph E. Holland, M.D.; Robert H. Hux, M.D.)

LEE — Larry P. Garrett, M.D.; H. Quillian Jones Jr., M.D.; Marcus M. Moore, M.D.; Douglas A. Newland; M.D.; Stephen R. Zellner, M.D. (Absent — F. Lee Howington, M.D.)

MADISON — (Absent — Michael O. Stick, M.D.)

MANATEE — Thomas R. Busard, M.D.; Robert A. Fasoli, M.D.; Julian Giraldo, M.D.; (Absent — William A. Boyce, M.D.; Roger A. Meyer, M.D.)

MARION — C. Brooks Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfore, M.D.

MARTIN — Fred S. Carter, M.D.; (Absent — Andrew F. Greene, M.D.; George E. McLain, M.D.)

MONROE — (Absent — Ronald H. Chase, M.D.)

NASSAU — (Absent — Robert L. Taylor, M.D.)

OKALOOSA — David R. Arrowsmith, M.D.; (Absent — William W. Thompson, M.D.)

ORANGE — Richard J. Bagby, M.D.; Clifford D. Bidwell, M.D.; Manuel J. Coto, M.D.; Robert T. Hoover, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Walter M. Philips Jr., M.D.; T. Byron Thames, M.D.; Cecil B. Wilson, M.D.; (Absent — Edward Ackerman, M.D.; Clarence M. Gilbert, M.D.; David L. Mackey, M.D.; Calvin R. Peters, M.D.; Robert N. Serros, M.D.; John P. Taggart, M.D.)

OSCEOLA — John R. Hartman, M.D.; Alonzo J. Logan, M.D.

PALM BEACH — Vernon B. Astler, M.D.; Lee A. Fischer, M.D.; J. Russell Forlaw, M.D.; Luis R. Guerro, M.D.; James M. Johnson, M.D.; V. A. Marks, M.D.; Myron M. Persoff, M.D.; William J. Romanos Jr., M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D.; (Absent — E. Joan Barice, M.D.; Robert Burger, M.D.; Richard C. Cavanagh, M.D.; Ralph R. Eastridge, M.D.; Charles E. Metzger, M.D.; Gilbert R. Panzer, M.D.; Ben R. Thebaut Jr., M.D.; James E. Vance, M.D.)

PANHANDLE — (Absent — James T. Cook Jr., M.D.; Herbert E. Brooks, M.D.)

PASCO — Carl W. Graves, M.D.; Vincent Cotroneo, M.D.; (Absent — Maynard F. Taylor, M.D.)

PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Anthony Garritano, M.D.; William E. Hale, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Jack A. MaCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Bruce P. Smith, M.D.; (Absent — Morris LeVine, M.D.; Howard L. Reese, M.D.; William Scmid, M.D.; Walter H. Winchester, M.D.)

POLK — Ronald W. Case, M.D.; Richard Garcia, M.D.; John W. Glotfelty, M.D.; William F. Hill, M.D.; David T. Jones, M.D.; John C. Moore, M.D.; Robert B. Peddy, M.D.; Daniel W. Welch, M.D.

PUTNAM — (Absent — Edward D. Risch, M.D.)

ST. LUCIE-OKEECHOBEE — Jack W. Barrett, M.D.; Khalil A. Cassimally, M.D.; Manuel G. Garcia, M.D.

SANTA ROSA — David B. Young, M.D.

SARASOTA — Richard J. Beebe, M.D.; John N. Carlson, M.D.; Robert W. Dein, M.D.; Kenneth C. Kiehl, M.D.; Franklin H. Pfeiffenberger, M.D.; Richard C. Rehmeyer, M.D.; Karl R. Rolls, M.D.; Ernest C. Smith Jr., M.D.; (Absent — David L. Thomas, M.D.)

SEMINOLE — Maria P. Perez, M.D.; (Absent — Humberto A. Dominguez, M.D.; Orlando Garcia-Piedra, M.D.)

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Philip L. Carey, M.D.)

TAYLOR — John H. Parker, M.D.

VOLUSIA — Harry F. Farmer, M.D.; Martin S. Feigenbaum, M.D.; Remigio G. Lacsamana, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Charles A. Stump, M.D.

WALTON — (Absent — James D. Lawlor, M.D.)

WASHINGTON — (Absent — Muhammad I. Zafar, M.D.)

SPEAKER OF HOUSE — James B. Perry, M.D.

VICE SPEAKER — Guy T. Selander, M.D.

COUNCIL ON HOSPITAL MEDICAL STAFFS — Raymond F. Barnes, M.D.

Information for Delegates

The Rules and Order of Business for the House of Delegates are included in this Handbook.

Delegates and alternates whose names appear in this Handbook have been certified by their county medical societies. **The Bylaws require that delegates fill out attendance cards at each meeting of the House of Delegates in order to be credited in attendance,** and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Your attention is called to the format of the Annual Meeting, where the Reference Committee meetings will be held in the morning following the First Meeting of the House. All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates. Members may request the Reference Committee chairmen to defer items in which they are interested in order that they may be present to discuss the subject.

All resolutions **must have a sponsor present before the Reference Committee.** Resolutions must be filed by 12:00 noon on the day of the First Meeting of the House of Delegates, typewritten and in proper form. The resolutions so presented will be available for distribution by the time the First House convenes. Only the "Resolved" portion of the resolutions will be adopted as policy.

All Reference Committee reports will be duplicated and available to the delegates at the Registration Desk on Saturday morning. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook, (as well as the reports of the Reference Committees) have been printed on colored paper for easy reference. This color code is as follows:

Reference Committee No. I — Green
Reference Committee No. II — Buff
Reference Committee No. III — Blue
Reference Committee No. IV — Pink
Reference Committee No. V — Goldenrod

According to our Bylaws, nominations and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

James B. Perry, M.D., Speaker
House of Delegates

Guy T. Selander, M.D., Vice Speaker
House of Delegates

A motion carried to adopt the Minutes of the 1984 House of Delegates as published in the August, 1984 issue of *The Journal of the Florida Medical Association, Inc.*

The Speaker introduced the officers of the Association: Guy T. Selander, M.D., Vice Speaker; Frank C. Coleman, M.D., President; Luis M. Perez, M.D., President-Elect; J. Lee Dockery, M.D., Immediate Past President; James G. White, M.D., Vice President; Henry M. Yonge, M.D., Secretary; Yank D. Coble Jr., M.D., Treasurer; Donald C. Jones, Executive Director.

Dr. Perry introduced distinguished guest Dr. Rufus K. Broadaway, AMA Trustee, Dr. Selander introduced Dr. Edward R. Annis, AMA Past President, and Dr. Coleman introduced Dr. Robert K. Casey, Gainesville, who delivered the certificate that qualified the more than 600,000 signatures to have Amendment 9 placed on the ballot by running from Gainesville to Tallahassee.

Remarks — Speaker of the House

A few years ago we all realized changes were occuring. These were beyond the control of physicians as individuals or associations representing their interests. Never in our wildest machinations did we believe the type of antagonistic, vituperative, hostile, aggressive action that we have seen exhibited by the Congress and State Legislatures, with echos of the media, could ever begin to occur.

Since our last formal get-together just one year ago, we have seen the Reciprocal go into receivership followed by a late end run by the Florida Supreme Court on Proposition 1 and then subsequent to that, Proposition 9, as well as the problems with our own professional liability, which threaten to destroy medicine as we know it today, the DRGs, and the PRO problem compounded the fracus. More recently we have seen the one year fee freeze and mandatory assignments becoming a Russian-type permafrost. Perhaps we are myopic, which I seriously doubt, in the list of our problems and regulations. No other profession, trying to do a decent job with controls and quality assurances, has ever been subjected to such harassment. We have survived this "uphill battle" and are here once again to try to and bring as much order and balance as possible under these circumstances, and to stabilize our Association and our own membership with the consentire of you our leaders.

In our position I hope that we can all communicate these efforts to the hospital staffs in our own county organizations and every physician in Florida. We need to answer their searching and necessary questions and receive their input in order to better deliberate and represent them here at this Annual Meeting.

As you know from previous years, but to reinterate briefly, our House of Delegates functions under the Rules of Order as published in *Sturgis Code of Parliamentary Procedure*. This will prevail unless otherwise provided for by the Florida Medical Association Charter or Bylaws, or unless waived or modified by a 2/3 vote of the members present of the House of Delegates.

The FMA Bylaws require Delegates to register by filling out cards at each meeting of the House. The Credentials Committee will attest to this and whether or not there is a quorum present. As a result, roll call will not be necessary.

The Reference Committees have been appointed and will meet to hear discussion and render a report compiled in their own executive session. Every member of the Florida Medical Association is invited to the hearings, to testify at them, and to participate in the discussions so that a consensus may be reached and decision, based on the majority of opinion, rendered and then submitted to this House. Authors or supporters of resolutions must be present to discuss their position and explain reasons for their proposal.

If an individual desires to discuss different issues in front of different Reference Committees and there is a time conflict, notification to the Chairman will suffice. He will take this into consideration and as a matter of courtesy, the problem will be handled expeditiously.

Council and Committee Chairmen are to be able to answer, enlighten, and encourage discussion over their area of expertise to members of the Reference Committee, as well as the membership. Each Reference Committee will have a senior staff person, a recording secretary, and an AMA delegate to monitor proceedings and assist in the discussions as necessary.

As in the past few years, to clarify double negatives, it is suggested that if a Reference Committee disapproves of a recommendation or a report, it should recommend a vote of "No" to the House.

Following the Reference Committees, their own executive sessions will be held and their reports completed. Reference Committee reports will be available for consideration by early Friday morning. This will usually be done in conjunction with the Speaker or Vice-Speaker. By early Saturday, the reports should be available to all delegations for consideration and caucus.

In an effort to expedite the meetings of the House, the Reference Committee will be encouraged to have a consent calendar. This portion will consist of items where there is no need for discussion. These statements will be listed as "approved, refer-

red, filed, or disapproved." Any member of the House can extract any portion of any of the consent calendar for general discussion by making a motion to extract it and having a simple majority vote in the House. This will enable that portion of the extracted consent calendar to be opened for extended debate should it be necessary. The reason for the consent calendar is to allow consideration on the floor with meaningful discussion about events which are more important and pertinent to the Association. Obviously, the more mundane, but nevertheless important, issues which do not need discussion can then be passed over by a simple consent agreement of the entire House.

We know that every delegate has the opportunity and privilege of discussion of any issue that a Reference Committee brings before the House for consideration. We would encourage that this be done in Reference Committee meetings. However, it is realized that this is not always possible and discussion on the floor is then necessary.

We want the majority to rule but the minority to have every opportunity to be heard and to influence the House.

In an effort to expedite the meetings, nominations for all elected officers will be held on Saturday afternoon after the end of the third Reference Committee report. Voting will then take place in booths on Sunday morning for the adjournment of the House. Hopefully, this will help to expedite and eliminate any confusion. We are hopeful that this procedure will allow the votes to be tallied more quickly and the House to be notified of the results in a most expeditious fashion.

We hope this refurbished hotel and the facilities will be conducive to a pleasant meeting with an enjoyable few days away from your practices. It is also hoped that the business of the Association will be expeditiously handled free from the turmoil and tarvail of the office and hospital practices through which we all exist.

God bless you and have a pleasant meeting.

The remarks of the Speaker of the House of Delegates were referred to Reference Committee III for consideration.

At this time, Dr. Perry proceeded to introduce FMA President, Frank C. Coleman, M.D.

Introduction of President

Dr. Frank Coleman took office one year ago at the Palace Hotel in Orlando. It is a long way from Jackson, Mississippi to a medical school in New Orleans, from the early days of pathology to a hotseat as President of the Florida Medical Association. In between, there was a lot of work, a lot of heartache and a honing of an individual who did many things at the Iowa state and AMA level.

His efforts, strengths and abilities are numerous and well known to many of you. I do not desire to reiterate these now. I do want to commend him for surviving, which he and all of us here, without reservation, call the most difficult year of existence in the history of the Florida Medical Association. We have seen some excellent men who wheeled the gavel over the last decade and before this, but never have any of them been required to spend 100 percent of every working day of the entire year tackling one significant crisis after another such as has occured this year. The results have been unbelievable.

In the first week of office, the insurance commissioner's restraining order caused the Association to use its entire resources and staff to rescue an ailing insurance company and save the assets of literally hundreds of Florida physicians whose very economic survival was on the line. It is the story of manipulative diplomacy that is unmatched in the history of Florida medicine.

The problem with the constitutional revision and the late end run by the Florida Supreme Court caused tremendous consternation but through all of this we have come out much stronger than if the resulting resolution had passed. We are however, much more in debt and financially ailing.

In an average year the Board of Governors meets four times. This year, including conference calls, there have been 19 meetings. This is uneneviable, and hopefully will be an unmatched record in the history of the Association.

Without further comment we all owe a debt of gratitude and tremendous praise and honor to a great friend and a job well done. It indeed was uphill all the way.

Thank you, Mr. President for your great year.

Dr. Coleman addressed the House (the text of Dr. Coleman's remarks appear on page 585). The remarks of the President were referred to Reference Committee III.

Dr. Coleman was then asked to assume the Chair to present the A.H. Robins Award for Outstanding Community Service by a Physician. Dr. Coleman introduced Mr. Jerry Kerlin, a representative of the A.H. Robins Company, and announced that Dr. H. Stewart Siddall of Tampa, Florida was the recipient of the award. Dr. Coleman requested that Dr. Glenn Hooper and Dr. Robert Isbell of Hillsborough County escort Dr. Siddall to the podium to receive the award.

A.H. Robins Company Award For Outstanding Community Service By a Physician

H. Stewart Siddall, M.D., a practicing General Surgeon in Tampa, Florida, has been selected by the Board of Governors of the Florida Medical Association, upon nomination of several medical professionals, as the recipient of the 1985 A. H. Robins Company Award for Outstanding Community Service by a Physician.

A native of Ravenna, Ohio, Dr. Siddall received his medical degree from St. Louis University School of Medicine. He did his internship at DePaul Hospital in St. Louis. He completed residencies at St. Joseph's Hospital, Alton, Illinois; Northwestern University School of Medicine, Wesley Memorial Hospital, Chicago; and completed a five-year surgery residency, including Chief Residency, at University of Cincinnati School of Medicine, Cincinnati General Hospital. He moved to Tampa in 1970 and established his general surgery practice.

Dr. Siddall has served as an instructor of Pathology at Northwest University, instructor of surgery, University of Cincinnati, instructor of surgery at St. Charles Hospital, a Clinical Associate Professor of Surgery at the University of South Florida College of Medicine and as an instructor of the Advanced Trauma Life Support Program.

As a United States Army Captain, Dr. Siddall served in Neurosurgery Service at the U.S. Army Hospital, Fort Campbell, Kentucky.

He is a member of American Medical Association, Florida Medical Association, Fellow, Southeastern Surgical Association, Hillsborough County Medical Association, Ohio State Surgical Society, Board of Directors of the Greater Tampa Chapter of the American Red Cross, and Phi Chi Medical Fraternity.

Presently, Dr. Siddall is the Chairman of the Disaster Planning Committee of the Hillsborough County Medical Association, Medical Consultant for the Greater Tampa Chapter of the

Dr. Frank C. Coleman, FMA President, presents the A.H. Robins Company Award to Dr. H. Stewart Siddall, of Tampa.

American Red Cross, Medical Director of the Mass Casualty Planning of Hillsborough County, a member of the Emergency Medical and Disaster Task Force of the Greater Tampa Chamber of Commerce Health Care Council, a member of the Disaster Committee at St. Joseph's Hospital and a member of the Hillsborough County Disaster Executive Committee.

As Chairman of the Hillsborough County Medical Association's Disaster Planning Committee, Dr. Siddall was instrumental in the Hillsborough County Board of County Commissioners establishing the office of Medical Director of Mass Casualty Planning in 1980. He has also successfully stimulated the development of reliable radio communications for mass casualty planning.

Additionally, Dr. Siddall assisted in the development of a Disaster Preparedness/Mass Evacuation plan for Tampa Stadium.

Mrs. Gloria Cook of Daytona Beach receiving the 1985 Distinguished Layman Award from FMA President, Frank C. Coleman, M.D.

Dr. Coleman proceeded to announce that Mrs. Gloria Cook of Daytona Beach was the recipient of the 1985 Distinguished Layman Award. Mrs. Cook was escorted to the podium by Dr. Alvin E. Smith of Ormond Beach and Dr. Richard Snodgrass of Daytona Beach.

Distinguished Layman Award
Mrs. Gloria Cook

Whereas, Gloria Cook of Daytona Beach, Florida, has been a tireless and generous supporter of Florida philanthropic and humanitarian causes since the early 1960's; and

Whereas, Her instrumental part in the Daytona Beach Junior Services League's establishment of the Orthopedic Clinic for the treatment of handicapped citizens and her service to this clinic in the capacity of a patient transporter and as a member of its Board of Directors has been of great magnitude; and Whereas, This distinguished individual in 1961, became President of the Easter Seal Society of Volusia County; and

Whereas, In 1962 she was appointed to the Board of Directors of the Florida Easter Seal Society where she served as Secretary, Vice President and President; and

Whereas, This kind woman was elected delegate to the House of Delegates of the National Easter Seal Society where she served this body as the first woman Vice Chairman and as Parlimentarian; and

Whereas, She served two terms as a member of the National Easter Seal Society Board of Directors where she served as third and second Vice President; and

Whereas, In 1980 she was elected to the Presidency of the National Easter Seal Society, becoming the first Floridian and the second woman to secure this post; and

Whereas, In 1967 she was appointed to the President's Commission on the employment of handicapped; and

Whereas, in 1969 she was the National Society's representative to the White House Conference on Food, Nutrition and Health; and

Whereas, This benevolent individual has served as an Auxiliary volunteer and as a member and Treasurer of the Board of Directors of Ormond Memorial Hospital; and

Whereas, This gracious lady has served as President of the Junior Service League, as a Red Cross Volunteer, as a member of the Board of Councillors of Bethune Cookman College, as Director of Public Relations for Seabreeze United Church and as an active member of the Florida Alumni Association of Volusia County; and

Whereas, Mrs. Cook continues to serve her community with her talent, energy and time; therefore be it

RESOLVED, That upon unanimous vote of the Board of Governors of the Florida Medical Association at its 111th annual Meeting in Hollywood, Florida, May 1-5, 1985, presents to Mrs. Gloria Cook its Distinguished Layman Award.

Medical Speakers Awards

The medical profession in Florida has benefitted in recent years from increased activity on the part of county medical societies and physicians in health-related television and radio programs.

This type of media activity is encouraged by the FMA. We established the Medical Speakers Awards to recognize some of these outstanding programs

and people who have made them successful. The First Place award winners receive a plaque and a check for $100.00. Second Place winners receive a framed certificate.

The First Place award for Organizational Television was presented to the Duval County Medical Society for their weekly program entitled *To Your Health*. This fifty-week series of programs represents a long-term commitment on the part of the Duval County Medical Society to give their community much needed medical and health information which helps the citizens better utilize the total health care delivery system. Dr. Jack L. Sapolsky, President of Duval County Medical Society, accepted the award.

The First Place award for Individual Television Performance goes to Dr. Joseph P. Fiore, of the Lee County Medical Society, last year's winner.

Dr. Fiore has been doing a series of weekly medical news segments entitled *To Your Health* since August of 1983. The program is aired regularly on the Fort Myers CBS affiliate, WINK-TV, as part of the local nightly news. This assures then a large viewing audience. Dr. Fiore devotes from eight to sixteen hours a week personally to this program. The award was accepted by Dr. Douglas A. Newland, President of Lee County Medical Society.

Second Place in the Individual Television Award went to Dr. Mitchell K. Schwaber of the Duval County Medical Society. Dr. Schwaber was cited for the excellent show he hosted concerning devices for the hearing impaired. This program was part of Duval County's *To Your Health* series. Dr. Jack L. Sapolsky accepted the award on behalf of Dr. Schwaber.

For the third year in a row, the winner in the Organizational Radio Category was the Duval County Medical Society. Their weekly call-in program entitled *Ask the Doctor* is broadcast over WEIX Radio in Jacksonville. Guest physicians talk about topics ranging from anesthesiology to urology. Once again, Duval County Medical Society is to be commended for their long-term commitment to the Medical/Health information needs of the Jacksonville community. Dr. Sapolsky accepted the award.

The final Speaker's Award, Individual Live Audiences, was presented to Dr. Lee A. Fischer of the Palm Beach County Medical Society. Dr. Fischer presented a talk entitled *Medicare HMO's: Get All the Facts Before Joining*. Over 2,000 people heard his presentation during the year at various Civic Clubs, churches and schools. His tireless efforts provided a real public service to the citizens of West Palm Beach. Dr. Fischer came forward to accept the award.

We would also like to extend our thanks to other medical groups around the state who submitted entries and encourage those of you who did not enter this year to enter next year. These programs, through your efforts, help to improve the image of the medical profession, for which we are all grateful.

At this time, Dr. Coleman presented the Harold S. Strasser, M.D., Good Samaritan Award to Richard Clemens Karl, M.D. of Tampa and Gaston J. Acosta-Rua, M.D. of Jacksonville.

Harold S. Strasser, M.D.
Good Samaritan Award
Richard Clemens Karl, M.D.

Whereas, Richard Clemens Karl, M.D., of Tampa, Florida, without concern for his own personal safety, welfare and comfort, committed an act of heroism beyond the call of his professional practice that saved the life of one of his fellow men; and

Whereas, While at work in the Tampa General Hospital, Dr. Karl went to the rescue of a despondent and suicidal patient who, despite security precautions, managed to get to a window with the obvious intention of leaping to his death; and

Whereas, Dr. Karl immediately intervened in this act of self-destruction by forcefully wrestling the patient from the window sill and into the safe confines of the room; and

Whereas, The confused and disoriented patient reacted violently, thrusting Dr. Karl aside and inflicting serious injury upon his person; and

Whereas, As a result of his altruistic act, Dr. Karl underwent decompressive laminectomy to his cervical spine and faces possible cervical fusion with prolonged halo type immobilization; and

Whereas, These injuries have caused Dr. Karl much pain and time lost from his practice; and

Whereas, Dr. Karl is a graduate of Cornell University Medical College and is presently the medical director of the H. Lee Moffit Hospital and Cancer Research Institute at the University of South Florida; and

Whereas, This physician humanitarian is a member of many medical organizations and is the author of many scientific articles and abstracts; therefore be it

RESOLVED, That upon the unanimous vote of the Board of Governors of the Florida Medical Association, the Harold S. Strasser, M.D. Good Samaritan Award be presented at the 111th Annual Meeting in Hollywood, Florida, May 1-5, 1985, to Richard Clemens Karl, M.D., with sincere appreciation for his humanitarian acts on behalf of his fellow man.

Harold S. Strasser, M.D.
Good Samaritan Award
Gaston J. Acosta-Rua, M.D.

Whereas, Gaston J. Acosta-Rua, M.D., of Jacksonville, Florida, has upon a notable occasion demonstrated exemplary humanitarian efforts unselfishly and to the benefit of his fellow man without concern for his own safety, welfare or comfort; and

Whereas, In 1984, after driving several hours from the nearest large city to Ometepec, Mexico, Dr. Acosta-Rua assessed the situation of a patient who was paralyzed from the neck down due to a gun shot wound suffered the day before; and

Whereas, This patient was being ventilated via tracheostromy and ambu bag with only his family to take turns with the ventilating, Dr. Acosta-Rua decided to transport this patient to a larger city, utilizing his van as a make-shift ambulance; and

Whereas, After driving about an hour over mountainous roads, the van caught fire and the travelers were evacuated; and

Whereas, Without regard for his personal safety, Dr. Acosta-Rua re-entered the van and dragged the patient to safety; and

Medical Speakers Awards

(1) Jack L. Sapolsky, M.D., President of Duval County Medical Society, accepts First Place Organizational Television, (2) Douglas A. Newland, M.D., President of Lee County Medical Society, accepts Individual Television Performance, (3) Lee A. Fischer, M.D., Palm Beach County Medical Society, accepts Individual Live Audiences, and (4) Jack L. Sapolsky, M.D., President of Duval County Medical Society, received Second Place Individual Television Performance. Dr. Sapolsky accepted the award for Mitchell K. Schwaber, M.D., from FMA President, Frank C. Coleman, M.D.

Frank C. Coleman, M.D., FMA President, presents the Harold S. Strasser, M.D., Good Samaritan Award to Richard C. Karl, M.D., of Tampa.

Whereas, While caring for the patient on the road, the still burning van began to roll down the hill toward them and Dr. Acosta-Rua again moved the suffering patient to safety; and

Whereas, This distinguished individual makes annual trips to remote areas of Mexico to give needy residents medical care; and

Whereas, This generous gentleman is a member of the American Medical Association, a member of the House of Delegates of the Florida Medical Association, a member of the Florida Neurological Society, a member of the Congress of Neurological Surgeons and a member of the Governing Board of Northeast Florida Health Agency; and

Whereas, Dr. Acosta-Rua is a member of the Meninak Club, the October Club, The Hispano-American Cultural Association and the Cuban-American Club; and

Whereas, Dr. Acosta-Rua was born in Cardenal, Cuba, and is a graduate of Havana University Medical School and Madrid University Medical; therefore be it

RESOLVED, That upon the unanimous vote of the Board of Governors, the Florida Medical Association at its 111th Annual Meeting in Hollywood, Florida, May 1-5, 1985 present to Gaston J. Acosta-Rua, M.D., the Harold S. Strasser, M.D., Good Samaritan Award with sincere appreciation for his humanitarian acts on behalf of his fellow man.

Frank C. Coleman, M.D., FMA President, presents the Harold S. Strasser, M.D., Good Samaritan Award to Gaston J. Acosta-Rua, M.D., of Jacksonville.

Presentation of the "Ruth Balle Resolution" was presented to Howard W. Pettengill, M.D., of Melbourne on behalf of Mrs. Ruth Balle with a duplicate award presented to Brevard County Medical Society also accepted by Dr. Pettengill.

Ruth Balle Recognition

Whereas, Ruth Balle has served with dignity, pride, and exceptional ability as Executive Director of the Brevard County Medical Society since 1966; and

Whereas, Ruth Balle has been a true friend to organized medicine and to the goals of all physicians and their families; and

Whereas, Ruth Balle has worked untiringly for the Brevard County Medical Society, making it a most respected and effective component of the Florida Medical Association; and

Whereas, Ruth Balle became a personal friend to many other county executive officers, to the Florida Medical Association staff, and to many physicians through the state including state officers who all held her in high regard; therefore be it

RESOLVED, That the Florida Medical Association pay an official tribute to this outstanding lady of medicine, Ruth Balle, who has served our profession with dignity, pride, ability, and tender loving care; and be it further

RESOLVED, That a copy of this resolution be delivered to Ruth, in the form of a certificate, and a copy be rendered to the Brevard County Medical Society office and it members.

Mike Lopez Resolution

Mrs. Kathy Lopez, escorted by Dr. William J. Ramanos, President of Palm Beach County Medical Society and Dr. Lee Fischer, Palm Beach, accepted the "Mike Lopez Resolution."

Resolution — Michael H. Lopez, Jr.: The Board expressed deep regret over the sudden and unexpected death of Mr. Michael Lopez, Executive Vice President of the Palm Beach County Medical Society, and adopted the following resolution:

Whereas, Mike Lopez met an untimely death on December 22, 1984; and

Whereas, Mike Lopez was a steadfast friend of organized medicine and to all physicians and physicians' families; and

Whereas, Mike Lopez worked untiringly for the Palm Beach County Medical Society making it one of the most respected and effective component medical societies; and

Whereas, Mike Lopez was a personal friend to many members of organized medicine; therefore be it

RESOLVED, That the Florida Medical Association pay an official tribute to Mike for his many contributions to organized medicine, and send a report of this action to his family in an expression of our deepest condolence.

1985 Awards for Excellence In Medical Journalism

Dr. Coleman then presented the Eighth Annual Florida Medical Association Awards For Excellence in Medical Journalism. This past year was an exciting and eventful one in the field of medicine, actively covered by journalists all over the state. How

Dr. Coleman presented to Mrs. Kathy Lopez a resolution honoring Michael H. Lopez Jr., Executive Vice President of Palm Beach County Medical Society.

eventful is illustrated by the entries in this awards contest. They cover a broad range of subjects, from Alzheimer's Disease to trauma treatment. New life-saving treatments made possible by modern medical technology were brought into public view, as were the issues of the "Bionic Body."

The purpose of this awards program is to recognize and thank journalists for their efforts and to encourage outstanding and responsible medical reporting.

The entries were judged by two panels of judges. The newspaper and magazine articles were judged by: John E. Ropp, President of Ropp Advertising; Roger Langston, General Manager, Centurian Press; Hank Drane, Media Consultant, FMA Communications; and Frederick W. Hartmann, Executive Editor, *Florida Times-Union*. The radio and television categories were judged by Dr. Patricia Cowdery of Jacksonville; Dr. F. Norman Vickers of Pensacola; Louis J. DiGiusto of the Florida Production Center and James A. Richardson, Director of Communications for FMA. We certainly would like to thank the judges for donating their valuable time to these awards.

Our First Place winners this year are from Dade, Alachua, Charlotte and Indian River Counties. Each winner in the six categories — Radio, Television, Newspapers, with circulation over 50,000, Newspapers with circulation under 50,000, Weekly Newspapers and Magazines — will be presented with a trophy and a check for $500.00.

The first award was in the Radio category. This year's first place entry was a feature news story entitled "More Than One Too Many — Habitual Drunk Drivers in South Florida." The story was presented by Frank Mottek of WINZ AM of Miami.

The death of a local teenage boy sparked a lot of controversy in Miami and pointed out the need for a trauma network in South Florida. Diana Gonzalez-Durruthy and Al Durruthy of WPLG-TV, Miami, put together an exhaustive, in-depth five-part series entitled "Trauma — When Seconds Count." This series earned them first place in our televsion category.

The next winner in the newspaper over 50,000 circulation was Mr. Horance G. "Buddy" Davis. "The Battle of Wounded Heart" was a gripping six-part account of Mr. Davis' experience with the medical care delivery system after suffering acute myocardial infarction. As he stated in article, "I died something like four times last October. Dying is a weird and depressing experience, leavened only by admiration for the alertness and skill of those who pounded life back into a spent shell."

Sam Rohlfing, a repeat winner in the newspaper under 50,000 circulation, could not be in attendance because of a long-planned out-of-the-country trip. She won the award again because of her consistently outstanding monthly health feature entitled, "Your Health" which appears in the *Vero Beach Press-Journal*. Donald L. Ames, M.D., Vero Beach, accepted the award on behalf of Sam Rohlfing.

The winner in the weekly newspaper category was also a repeat winner from last year. Gene Casey of the *Charlotte Sun* was unable to attend last year's awards because he was undergoing an operation and treatment for Stage 4 oral cancer. Given a 50-50 shot at survival, Gene Casey made two decisions: "To Fight Like Hell To Survive" and to record the experience in his weekly page-one column in the *Charlotte Sun*. He accomplished both feats with remarkable success.

Our final category was magazines. Fraser Kent of the *Miami-South Florida Magazine* was awarded first place for his in-depth article entitled, "At Last: Good News About Cancer." This article looked at the tremendous strides being made in cancer research, diagnosis and treatment. Mr. Kent won second place in this category last year. We would like to congratulate him for doing a consistent outstanding job in medical journalism.

One of the above winners, judged the best of all entries, received the Ernest R. Currie Memorial Media Award which memorializes the Duval County Medical Society's Executive Vice President who served from 1968 until his death in 1984. Mr. Currie became involved in organized medicine following a successful career in broadcasting. He effectively utilized his expertise in the media to further the cause of medicine by establishing both a radio and a cable television program for the medical society and a weekly newspaper column. The First Annual Ernest R. Currie Memorial Media Award was presented to Mr. Horance G. "Buddy" Davis of the

Dr. Coleman presented the First Annual Ernest R. Currie Memorial Media Award to Mr. Horance G. "Buddy" Davis of the *Gainesville Sun*.

Gainesville Sun for his series entitled "Battle of Wounded Heart."

The Second Place Awards as well as the Honorable Mentions, consisting of a certificate and a check for $200, will be presented by the appropriate county medical society at a later date. Dr. Coleman then announced these winners.

In Radio, Second Place went to Rebecca Randall of WDBO, Orlando, for her feature news report entitled "The Catastrophic Disease".

Second Place in Television was awarded to Art Carlson of WPLG-TV in Miami for his three-segment work entitled "The Body Bionic," "Biofeedback and Paralysis," and Refractive Surgery."

Due to the extremely high quality of television entries, the judges awarded three Honorable Mentions. An Honorable Mention for Community Service went to Adele Tyre of WTSP-TV, St. Petersburg for her entry, "An Age Old Fear: Alzheimer's." Other Honorable Mention Awards goes to Bret C. Snyder, Leisa Zigman and Ron Krauss, WUFT-TV, Gainesville, for their entry "Emptying the Warehouses: Florida's Cluster Home Projects" and to L.J. Haney, C.W. Craig and Mitchell Haley of Lee Memorial Hospital Media Services, Ft. Meyers, for their entry, "Medical Digest."

Second Place in daily newspapers with circulation over 50,000 went to Shari Roan of the *Ft. Lauderdale News & Sun Sentinel* for her article "Toxic Shock Syndrome: A Case of Neglect" and to Tom and Pam O'Hara of the *Miami Herald* for their feature "In Sickness and In Health."

Second Place in newspapers with under 50,000 circulation was awarded to Susan Peterson of the *Sun-Tattler*, Hollywood, for her article "Human Genetics."

Tom Denhaver of *The Sun* in Sun City Center was awarded Second Place in the weekly newspaper category for his article "HMO — Cure or Cancer."

Second Place in Magazines went to Rosemary Gondreau of the *Orlando Sentinel* for her feature story entitled, "Felicia's Story."

Sanford A. Mullen, M.D., Award

President Coleman called on Wayne Schrader, M.D., President of the Florida Society of Pathologists, to present the fourth annual Sanford A. Mullen, M.D., Award. Dr. Schrader presented the award to Lawtey E. McHenry, M.D. Board certified in both clinical and anatomical pathology as well as nuclear medicine, Dr. McHenry has served twice as President of the Florida Society of Pathologists. He is a delegate to the College of American Pathologists and a Board member of the American Society of Clinical Pathologists. He has served as Medical Examiner for Brevard County since 1964, and in 1972 was appointed District Medical Examiner by the Governor of Florida.

Corrections to the Handbook were then announced by the Vice Speaker:

Several County Medical Society Presidents had changed since the Handbook was printed. The list of Privilege of the Floor was changed appropriately.

The Speaker then recognized several officers of the FMA Auxiliary who were present: Mrs. Jo Tignor, President-Elect, Mrs. Sandy Whittaker, Secretary, and Mrs. Priscilla Gerber, 1985-86 AMA-ERF Chairman.

Dr. Lawtey E. McHenry (left) accepted the Sanford A. Mullen, M.D., Award from Florida Society of Pathologists President, Dr. Wayne Schrader (right).

Presentation by Auxiliary President Mrs. Laurin G. (Nancy) Smith

Thank you. Dr. Coleman, FMA members and guests. The Florida Medical Association Auxiliary has been in action all year and I am pleased to announce some of our many accomplishments. Our second annual Media Day was held in October. We had varying degrees of success around the state, but we felt we were successful in opening the eyes of the journalists to the activities and the participation of medical families.

Our Committee on Aging worked overtime. Working closely with the Florida Medical Association, our Public Relations Chairman, the Medi-File was designed by Auxilian Ann Swing and distributed at Fall Conference. Adele Graham, the Governor's wife, endorsed our Medi-File by making a public service announcement on television which has run frequently around the state. We have also been asked by fourteen other states to use our Medi-Files in their home states. We have also attended the Governors's Commission on Aging and at this time are actively supporting legislation on Alzheimer's Disease. Our Special Auxiliary Issue of *The Journal of the Florida Medical Association, Inc.*, featured aspects of aging from a new and creative angle. The articles were up-beat and educational, giving emphasis to the healthy older adult and emphasizing positive contributions this growing segment of our population represents. After the FMA Auxiliary won the national award last year for the most monies ever collected for AMA-ERF, we were frightened that this year would be somewhat of a let down. On the contrary, all the counties have pulled together and I believe we might just pull it off again. At this moment, we have $111,000 and all the figures are not in yet. And, we have renewed interest in health career activities. Lee County showed us with the formation of a $650,000 grant for endowed share of nursing at the University of South Florida, Ft. Myers, that we can make a critical difference. I might add less than 12 women worked on the project and they raised that money in less than three months. Broward County also receives real credit for the $14,500 they put together for scholarships this year. The Auxiliary feels the need for well trained personnel in the allied health field. This need is especially great in Florida, where because of the rising population, health care is predicted to be the number one industry in the state. From our educational projects to our legislative activities, to our quarterly magazine and to our internal projects which advance the Auxiliary's goal of promoting friendlier relationships among medical families, we are proud of our year and we are especially proud of the warm cooperative relationship we have with the Florida Medical Association.

Thank you.

Dr. Coleman was presented a plaque symbolic of his up-hill battle during his tenure as FMA President.

Dr. Perry announced that in the interest of time the names of the members of the Reference Committees who were appointed and assigned would not be read. However, they were listed in the Handbook and would be introduced individually when they gave their reports and at the time of their presentations in front of the various members of the Association. Dr. Perry then announced the times that each Reference Committee would meet.

Reference Committee No. I
Health and Education

Alvin E. Smith, M.D., Chairman, Volusia
Gaston Jose Acosta-Rua, M.D., Duval
Robert B. Peddy, M.D., Polk
Hector Mendez, M.D., Orange
Dolores A. Morgan, M.D., Dade
Douglas A. Newland, M.D., Lee
AMA Delegate Advisor: Richard G. Connar, M.D.
(Alternate — Charles J. Kahn, M.D.)

Reference Committee No. II
Public Policy

Luis R. Guerrero, M.D., Chairman, Palm Beach
Michael R. Redmond, M.D., Escambia
Charles S. Eytel, M.D., Collier
Wallace M. Philips Jr., M.D., Orange
Harold G. Norman, M.D., Dade
Paul A. Flaten, M.D., Broward
John W. Glotfelty, M.D., Polk
AMA Delegate Advisor: Robert E. Windom, M.D.
(Alternate — Joseph T. Ostroski, M.D.)

Reference Committee No. III
Finance and Administration

Margaret C. S. Skinner, M.D., Chairman, Dade
James T. Cook III, M.D., Bay
John C. Moore, M.D., Polk
Virgil A. Ponzoli Jr., M.D., Collier
Robert H. Hux, M.D., Lake
Glenn S. Hooper, M.D., Hillsborough
AMA Delegate Advisor: T. Byron Thames, M.D.
(Alternate — O. William Davenport, M.D.)

Reference Committee No. IV
Legislation and Miscellaneous

Kenneth C. Kiehl, M.D., Chairman, Sarasota
David R. Arrowsmith, M.D., Okaloosa
Thomas R. Busard, M.D., Manatee
E. Joan Barice, M.D., Palm Beach
Charles A. Dunn, M.D., Dade
Arnold L. Tanis, M.D., Broward
Samuel L. Renfroe, M.D., Marion
AMA Delegate Advisor: Louis C. Murray, M.D.
(Alternate — Sanford A. Mullen, M.D.

Reference Committee No. V
Medical Economics

Charles P. Hayes Jr., M.D., Chairman, Duval
John M. Canakaris, M.D., Flagler
Robert L. Dawson, M.D., Pinellas
Alan J. Yesner, M.D., Broward
Charles B. McIntosh, M.D., Duval
Miguel Figueroa, M.D., Dade
Ralph E. Rydell, M.D., Hillsborough
Jack W. MacDonald, M.D., Capital
AMA Delegate Advisor: Joseph C. Von Thron, M.D.
(Alternate — Dick L. Van Eldik, M.D.

Dr. Perry announced that the assignments of reports and resolutions to Reference Committees were as indicated in the Handbook.

The Vice Speaker announced the assignments of Supplemental Reports and Resolutions which were received too late for inclusion in the Handbook and which had been inserted into the Delegates packets as indicated on the reports.

The Speaker called for any reports which had were received too late to be included on the agenda. The Council on Hospital Medical Staffs met for the first time and were unable to submit their resolution by 12:00 noon and according to the Bylaws, all resolutions received after 12:00 noon must have an unanimous consent of the House. The motion to consider this resolution passed.

Dr. Perry announced the dates and times of the Auxiliary Reception and Art Auction, Blue Cross and Blue Shield Informational Meeting, Florida Physicians Association Annual Membership Meeting, the General Session, Tee-off time for the Golf Tournament, the FMA Symposium "Quality Medicine in a Rapidly Changing Environment," the President's Reception, the FLAMPAC/Auxiliary Luncheon, and the Health Run.

The House recessed at 6:00 p.m. to reconvene on Saturday, May 4, at 3:00 p.m.

President's Reception

(1) Dr. and Mrs. Joseph C. Von Thron (2) Dr. and Mrs. George S. Palmer (3) FMA President Dr. Frank C. Coleman and Mrs. Ruth Coleman (4) Left to right: Dr. Luis M. Perez, President-Elect, Dr. Maria Perez, Mrs. Ruth Coleman, and Dr. Frank C. Coleman, President (5) Dr. and Mrs. A. Frederick Schild are greeted by President-Elect Dr. Luis M. Perez and Dr. Maria Perez (6) Dr. and Mrs. Rufus K. Broadaway (7) FMA Staff Members (left to right) Ms. Joann Gore, Ms. Sara Karppe, and Ms. Debbie Graft (8) Dr. and Mrs. A. Frederick Schild all enjoy the Annual President's Reception.

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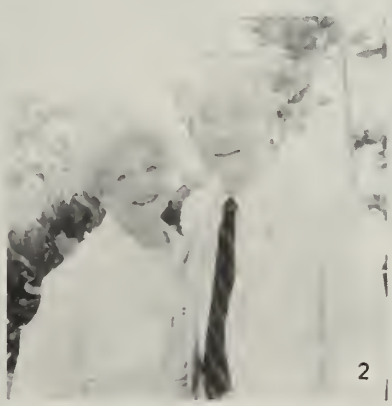
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Editor's Dinner

This year's Editor's Dinner was the last for the Editor, Daniel B. Nunn, M.D., who served as Editor for five years. (1) Left to right: Mrs. Ruth Coleman, President Frank C. Coleman, Dr. Nunn, President-Elect Dr. Luis M. Perez, Dr. Maria Perez (2) Two past Editors (left to right) Dr. Gerold L. Schiebler, Dr. Clyde M. Collins and Dr. Nunn (3) Dr. Nunn and Dr. E. Charlton Prather (4) Dr. Nunn was presented a plaque from the Board recognizing his accomplishments as Editor for the past five years (5) Dr. and Mrs. Lee Fischer enjoy the Editor's Dinner (6) Dr. T. Byron Thames (7) Dr. Clyde M. Collins (8) Dr. R. G. Lacsamana (9) Dr. Robert C. Fore all pay tribute to Dr. Nunn.

General Session

The General Session of the 111th Annual Meeting of the Florida Medical Association, Inc., was called to order at 11:10 a.m. on Friday, May 3, 1985, in the Regency East/South Room of the Diplomat Hotel, Hollywood, Florida.

Dr. Coleman introduced the officers seated at the head table and then recognized certain distinguished guests.

Dr. Coleman then invited Dr. Luis M. Perez, President of the Florida Medical Foundation and Mrs. Nancy Smith, President of the FMA Auxiliary to come to the podium for the presentation of grants from the AMA-ERF to medical school deans. Mrs. Smith introduced Mrs. Joan Selander, State AMA-ERF Chairman.

Checks were presented to Dr. William B. Deal, Dean, University of Florida, College of Medicine, Gainesville; Dr. Bernard J. Fogel, Dean, University of Miami, School of Medicine, Miami; Dr. Andor Szentivanyi, Dean, University of South Florida, Tampa. Dr. William B. Deal accepted the check on behalf of The Program in Medical Sciences, Florida State University.

After these presentations, Mrs. Smith made a special presentation to Dr. Perez of a check for $5330.16 for the Impaired Physicians Program of the Florida Medical Foundation. Mrs. Smith introduced Mrs. Charlotte Wright, State FMF Chairman.

Dr. Coleman then announced the winners of the 1985 Scientific Exhibit Awards.

1985 Scientific Exhibit Awards

First Place:
"An Early Approach to Correction of Severe Facial Deformity by Combined Cranio-Facial Surgery"
Mutaz B. Habal, M.D., Tampa

Second Place:
"Cocaine Abuse: Detection and Treatment"
Irl Extein, M.D.

Third Place:
"Gastric Restrictive Surgery (Stapling) for Morbid Obesity — Experience of 800 Cases"
Alex M. MacGreggor, M.D., Gainesville

Honorable Mention:
"Flexible Sigmoidoscopy — Why and How?"
John P. Christie, M.D., South Miami

"Preserving Tissue in Fingertip Injuries"
Merlin Anderson, M.D., Tampa

"Help for the Totally Deaf — The Cochlear Implant"
Frederic W. Pullen II, M.D., Miami

On behalf of Dr. Daniel B. Nunn, Editor of *The Journal*, Dr. Pierre J. Bouis Jr., announced the winner of the Editor's Award which is presented annually to the best entry in the Auxiliary Art Show. This year's winning entry was "Purple Vein" by Michele Schiebler, Gainesville. The winning entry traditionally appears on the cover of the Proceedings Issue of *The Journal*.

Dr. Bouis then announced the winners of the Eighth Annual JFMA Awards Contest For County Medical Society Bulletins.

Winners of Eighth Annual JFMA Awards Contest For County Medical Society Bulletins

Category 1 — General Excellence
First Place: Volusia County *The Stethoscope*
R. G. Lacsamana, M.D., Editor

Special Citation: Dade County *Miami Medicine*
Richard J. Feinstein, M.D., Editor

Category II — Most Improved Bulletin
First Place: *Hillsborough County Bulletin*
John E. Perchalski, M.D., Editor

Special Citation: *Escambia County Bulletin*
F. Norman Vickers, M.D., Editor

Category III — Best Editorial
First Place: Dade County *Miami Medicine*
Richard J. Feinstein, M.D., Editor

Special Citation: *Marion County Bulletin*
Henry L. Harrell Jr., M.D., Editor

Category IV — Best Regular Feature
First Place: *Lee County Bulletin*
F. Lee Howington, M.D., Co-Editor
Kim Spear, M.D., Co-Editor

Category V — Special Recognition
First Place: *Polk County Bulletin*
John W. Glotfelty, M.D., Editor

Dr. James H. Sammons, Executive Vice President of the American Medical Association, presented the annual Baldwin Lecture.

Dr. Coleman then introduced the 1985 Abel S. Baldwin lecturer, Dr. James H. Sammons, Executive Vice President of the American Medical Association.

Dr. Sammons is recognized as one of the nation's leading spokesmen on health issues. In a poll conducted by *U.S. News and World Report*, leaders ranking their peers placed Dr. Sammons first in the prestigious list of decision makers in the American health care field.

Dr. Sammons began his remarks by reminding physicians that they and Dr. Baldwin in 1874 had in common the physician-patient relationship which results in "expressions of faith." "Patient selection of a physician," Dr. Sammons explained, "and physician acceptance of a patient, also constitute the expression of a mutual faith, and it can be essential to the cure."

Dr. Sammons stated that preserving this faith is one of AMA's foremost priorities, along with preserving the excellence of medical education and patient care delivery system. The progress medicine has made since 1874 has created many problems, he went on, concerning ethical and legal issues involving treatment. Because the American public expects perfect results from medicine, physicians are being taken to court when the perfect result is not achieved, resulting in a professional liability insurance crisis.

"Modern medicine also is high cost medicine," Dr. Sammons said, "so in health care, cost restraint has become the number one song on the nation's legislative and regulatory charts with private and public payers singing in the chorus." Dr. Sammons explained that "we use the abiding faith in our own profession to help ourselves and ultimately our patients and society at large" when dealing with DRG's, PRO's, and other cost containment programs. The AMA has programs available to help physicians and their staffs to function more efficiently and competitively in the marketplace, he added as well as a program that provides demographic information about a location to aid physicians who are just starting or relocating their practices.

Dr. Sammons also described the AMA's new Special Task Force on Professional Liability, whose reports and recommendations for action have been commended by newspapers such as *The Chicago Tribune* and *USA Today*. After describing problems associated with DRG's, PRO's and other cost-containment programs, Dr. Sammons assured his listeners that the AMA was keeping a close watch on all these programs. He expressed his disbelief that the "people of this country will allow undue damage be done to a medical and health services system to provide them with the best kind of care." He added, "We shouldn't provide more care than is really needed, but we will insist on providing as much as is really needed. With our profession that too is an article of faith."

Eighth Annual JFMA Awards Contest

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Seven county medical societies received plaques in the Eighth Annual Journal of the Florida Medical Association Awards Contest for County Medical Society Bulletins. The awards were presented at the annual Editor's Dinner. (1) Dr. John E. Perchalski, Editor, Hillsborough County Bulletin accepts the award for Most Improved Bulletin (2) Dr. A. Frederick Schild accepts the Best Editorial Award for Miami Medicine, on behalf of the Editor, Dr. Richard J. Feinstein (3) Dr. John W. Glotfelty, Editor, Polk County Bulletin accepts the Special Recognition Award (4) On behalf of Dr. F. Norman Vickers, Editor, Escambia County Bulletin, Dr. Henry M. Yonge accepts the Special Citation in the Most Improved Bulletin category (5) Dr. R. G. Lacsamana, Editor, Volusia County Bulletin accepts the award for General Excellence (6) Mrs. Ann Wilke, Executive Secretary of Lee County Medical Society, accepts the award for Best Regular Feature for Drs. F. Lee Howington and Kim Spear (7) Dr. Henry L. Harrell Jr., Editor, Marion County Bulletin accepts a Special Citation in the Best Editorial category.

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Annual Meeting Highlights

(1) Dr. and Mrs. Frank C. Coleman greet Andor Szentivanyi, M.D., Dean of the University of South Florida College of Medicine (2) Past President J. Lee Dockery, M.D., and his wife Barbara (3) President-Elect Luis M. Perez, M.D. (center) welcomes his sons Hector "Tico" (left) and Luis M. Perez Jr. (right) (4) FMA Executive Director Donald C. Jones (right) welcomes Laurin G. Smith, M.D., and Mrs. S. Bruce (Priscilla) Gerber (5) Dr. and Mrs. Emmet F. Furguson Jr. (left) and JFMA Editor Daniel B. Nunn, M.D., and Mrs. Nunn (Gloria) (6) FMA Past Presidents (left to right) O. William Davenport, M.D., Vernon B. Astler, M.D., T. Byron Thames, M.D., and Joseph C. Von Thron, M.D.

(7) FLAMPAC President Robert E. Windom, M.D. (left), Laurin G. Smith, M.D., Vero Beach, and Douglas Kiker, NBC News Correspondent (8) FMA Staff (left to right) Sissy Crabtree, Janice Danson, Bob Harvey, Lee Pass, and Marcia Protheroe (9) Annual Health Fun Run (10) FMA Staff at Delegate Registration. Left to right, Lee Pass, Cindy Curry, and Marcia Protheroe (11) Dr. and Mrs. Frank C. Coleman and Past JFMA Editor Clyde M. Collins, M.D., (right) (12) Jere W. Annis, M.D., and (right) Past President Samuel M. Day, M.D.

Second House of Delegates

The Second House of Delegates convened at 3:15 p.m., Saturday, May 4, 1985 in the Regency East/South Room of the Diplomat Hotel, Hollywood, Florida with Dr. James B. Perry, Speaker of the House, presiding.

Dr. Gerald Stoker of the Credentials Committee reported that 221 Delegates were present with 36 component county societies represented, constituting a quorum, and moved that the Delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; Elayne E. Cassisi, M.D.; Robert K. Casey, M.D.; Richard M. Fry, M.D.; William T. Hawkins, M.D.; Gerold L. Schiebler, M.D.; Michael Fagien, Student Delegate.

BAY — James T. Cook III, M.D.; Terrence R. Steiner, M.D.; (Absent — B. Philip Cotton, M.D.)

BRADFORD — (Absent — Carlos M. Hernandez, M.D.)

BREVARD — John B. Adamson, M.D.; Raymond A. Armstrong, M.D.; Richard I. Barr, M.D.; Antonio Catasus, M.D.; Brian J. Ellis, M.D.; Howard W. Pettengill, M.D.; Robert C. Ufferman, M.D.

BROWARD — Walter A. Campbell, M.D.; Andre S. Capi, M.D.; Thomas E. Corley, M.D.; David A. D'Alessandro, M.D.; George T. Edwards, M.D.; Ira Finegold, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; John M. Harper, M.D.; William C. Hartley, M.D.; Wayne R. Johnson, M.D.; George P. Mesenger, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Ray E. Murphy Jr., M.D.; Ernest G. Sayfie, M.D.; Richard D. Shafron, M.D.; Arnold L. Tanis, M.D.; H. Murray Todd, M.D.; Alan J. Yesner, M.D.; (Absent — Phillip A. Caruso, M.D.; George J. Crane, M.D.; Arthur L. Eberly, M.D.; Theodore W. Hahn, M.D.; David C. Lane, M.D.; Joseph M. Sachs, M.D.; Donald D. Sheffel, M.D.; Marvin L. Stein, M.D.; Juan S. A. Wester, M.D.)

CAPITAL — Robert P. Johnson, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Terence P. McCoy, M.D.; Robert N. Webster, M.D.

CHARLOTTE — Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; Luis H. Serentill, M.D.

CITRUS — W. Randall Jenkins, M.D.; Samuel R. Miller, M.D.

CLAY — Clarence M. Harris, M.D.

COLLIER — Charles S. Eytel, M.D.; Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.

COLUMBIA — Nanjunda Swamy, M.D.

DADE — Jerome Benson, M.D.; Pedro P. Bosch, M.D.; Robert E. Boyett, M.D.; James W. Bridges, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; Richard C. Clay, M.D.; Vincent P. Corso, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Norman T. Ditchek, M.D.; Barbara Drabkin, M.D.; Charles A. Dunn, M.D.; Byron D. Epstein, M.D.; Miguel Figueroa, M.D.; Denio O. Fonseca, M.D.; Simon Frank, M.D.; Antonio F. Frexes, M.D.; Richard L. Glatzer, M.D.; Joseph Harris, M.D.; Donald E. Johnson, M.D.; Maurice H. Laszlo, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Linda Marraccini, M.D.; Miguel A. Mora, M.D; Dolores A. Morgan, M.D.; Sheldon D. Munach, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Manuel A. Porto-Sastre, M.D.; Pedro A. Ramos, M.D.; Jeffrey B. Raskin, M.D.; Harry T. Remmer, M.D.; William I. Roth, M.D.; Oscar Sandoval, M.D.; A Fredrick Schild, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; Margaret C.S. Skinner, M.D.; Douglas Slavin, M.D.; Marvin B. Slotkin, M.D.; Charles F. Tate, M.D.; Emilio A. Trujillo, M.D.; Osvaldo D. Valdes, M.D.; Harold H. Weiner, M.D.; Leo Whitman, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; (Absent — Manuel Abella-Fernandez, M.D.; Edward R. Annis, M.D.; Harlon S. Chiron, M.D.; N. Ralph Frankel, M.D.; Samuel P. Stokley, M.D.; Claudio R. Villoch, M.D.; Ana Isabel Gonzalez, Student Delegate.)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Gaston J. Acosta-Rua, M.D.; Clyde M. Collins, M.D.; James H. Corwin II, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Walter A. Harmon, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; John F. Lovejoy, M.D.; Charles B. McIntosh, M.D.; Charles T. Montgomery, M.D.; Kurt W. Mori, M.D.; John A. Rush, M.D.; Jack L. Sapolsky, M.D.: Sedbury D. Stoneburner Jr., M.D.; Robert H. Threlkel, M.D.; George S. Trotter, M.D.; James W. Walker, M.D.; H. Warner Webb, M.D.; (Absent — William P. Booras, M.D.; Daniel B. Nunn, M.D.)

ESCAMBIA — Richard H. Ciordia, M.D.; Eric F. Geiger, M.D.; Charles J. Kahn, M.D.; Michael R. Redmond, M.D.; Robert K. Wilson Jr., M.D.; Henry M. Yonge, M.D.; (Absent — C. Fenner McConnell, M.D.)

FLAGLER — John M. Canakaris, M.D.

FRANKLIN-GULF — (Absent — Joseph P. Hendrix, M.D.)

HERNANDO — Clinton J. McGrew Jr., M.D.

HILLSBOROUGH — Richard J. Bagby, M.D.; Frank C. Coleman, M.D.; Richard G. Connar, M.D.; Thomas H. Greiwe, M.D.; Richard S. Hodes, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Ralph E. Rydell, M.D.; Stewart Siddall, M.D.; Gerald L. Stoker, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D.; (Absent — Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Thomas E. McKell, M.D.; Ronald L. Seeley, M.D.; Harold L. Williamson, M.D.; T. Roland Reeves, Student Delegate.)

INDIAN RIVER — Paul A. Graham, M.D.; Kip G. Kelso, M.D.; (Absent — Donald L. Ames, M.D.)

LAKE — Joseph A. Comfort, M.D.; Joseph E. Holland, M.D.; Robert H. Hux, M.D.

LEE — Larry P. Garrett, M.D.; H. Quillian Jones Jr., M.D.; Marcus M. Moore, M.D.; Douglas A. Newland, M.D.; Stephen R. Zellner, M.D.; (Absent — F. Lee Howington, M.D.)

MADISON — (Absent — Michael O. Stick, M.D.)

MANATEE — Thomas R. Busard, M.D.; Robert A. Fasoli, M.D.; Julian Giraldo, M.D.; Robert A. Meyer, M.D.; (Absent — William A. Boyce, M.D.)

MARION — Claude B. Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; Andrew F. Greene, M.D.; George E. McLain, M.D.

MONROE — Ronald H. Chase, M.D.

NASSAU — (Absent — Robert L. Taylor, M.D.)

OKALOOSA — David R. Arrowsmith, M.D.; William W. Thompson, M.D.

ORANGE — Richard J. Bagby, M.D.; Clifford D. Bidwell, M.D.; Manuel J. Coto, M.D.; Edward Farrar, M.D.; Wayne L. Godbold, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Calvin R. Peters, M.D.; Wallace M. Phillips, M.D.; Philip N. Styne, M.D.; T. Byron Thames, M.D.; Cecil B. Wilson, M.D.; (Absent — Henry J. Baskin, M.D.; David L. Mackey, M.D.; Robert N. Serros, M.D.)

OSCEOLA — John R. Hartman, M.D.; Alonzo J. Logan, M.D.

PALM BEACH — Vernon B. Astler, M.D.; E. Joan Barice, M.D.; Richard C. Cavanagh, M.D.; Ralph R. Eastridge, M.D.; Lee A. Fischer, M.D.; George L. Ford, M.D.; J. Russell Forlaw, M.D.; Luis R. Guerrero, M.D.; James M. Johnson, M.D.; V. A. Marks, M.D.; Gilbert R. Panzer, M.D.; Myron M. Persoff, M.D.; William J. Romanos Jr., M.D.; Joel F. Smith, M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D.; (Absent — Robert Burger, M.D.; Ben R. Thebaut Jr., M.D.)

PANHANDLE — Herbert E. Brooks, M.D.

PASCO — Vincent Cotroneo, M.D.; Carl W. Graves, M.D.; (Absent — Maynard F. Taylor, M.D.)

PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Anthony Garritano, M.D.; William E. Hale, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris LeVine, M.D.; Jack A. MaCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Bruce P. Smith, M.D.; (Absent — Howard L. Reese, M.D.; William H. Schmid, M.D.; Walter H. Winchester, M.D.)

POLK — Ronald W. Case, M.D.; Richard Garcia, M.D.; John W. Glotfelty, M.D.; William F. Hill, M.D.; David T. Jones, M.D.; John C. Moore, M.D.; Robert B. Peddy, M.D.; Daniel W. Welch, M.D.

PUTNAM — Edward D. Risch, M.D.

ST. LUCIE-OKEECHOBEE — Khalil A. Cassimally, M.D.; David L. Fromang, M.D.; (Absent — Manuel G. Garcia, M.D.)

SANTA ROSA — David B. Young, M.D.

SARASOTA — Jack E. Baron, M.D.; Richard J. Beebe, M.D.; John N. Carlson, M.D.; Kenneth C. Kiehl, M.D.; Franklin H. Pfeiffenberger, M.D.; Richard C. Rehmeyer, M.D.; Ernest C. Smith Jr., M.D.; David L. Thomas, M.D.; (Absent — Robert W. Dein, M.D.)

SEMINOLE — Humberto A. Dominguez, M.D.; Orlando Garcia-Piedra, M.D.; Maria P. Perez, M.D.

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Philip L. Carey, M.D.)

TAYLOR — (Absent — John H. Parker, M.D.)

VOLUSIA — Harry F. Farmer, M.D.; Martin S. Feigenbaum, M.D., Remigio G. Lacsamana, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Charles A. Stump, M.D.

WALTON — (Absent — James D. Lawlor, M.D.)

WASHINGTON — (Absent — Muhammad I. Zafar, M.D.)

SPEAKER OF THE HOUSE — James B. Perry, M.D.

VICE SPEAKER — Guy T. Selander, M.D.

COUNCIL ON HOSPITAL MEDICAL STAFFS — Raymond F. Barnes, M.D.

Dr. Perry requested that Dr. Coleman announce the winners of the FMA Golf Tournament. First Place was Vernon B. Astler, M.D. and Second Place was James G. White, M.D.

Dr. Coleman also announced the winners of the 1985 Health Run. In First Place with a running time of 20:16 was Mr. George Markovich; Second Place with a running time of 20:19 was Dr. John Hartman; and Third Place with a running time of 20:44 was Dr. Richard Garcia.

Dr. Coleman then announced the Technical Exhibit Winners. In First Place was Dr. Joan Harris; Second Place was Loyce Glass; and Third Place was Edward W. Stoner.

Dr. Perry then recognized Dr. David Thomas, Dr. Bernard Kimmel, and Dr. "Doc" Myers. Dr. Perry also asked that recognition in the form of applause be given to the Reference Committees for the responsibility, difficulty, and complexity involved this year in preparing the reports.

Report of Reference Committee No. 1 Health and Education

Dr. Perry called the Chairman and members of Reference Committee I, Health and Education, to present the Report.

Dr. Alvin E. Smith, Chairman, and his Committee came forward to present the report of Reference Committee I, Health and Education.

Report of the Council on Scientific Activities

The Report of the Council on Scientific Activities was adopted.

The Council on Scientific Activities has had an extremely active year meeting four times in conjunction with meetings of component committees and subcommittees. Council and committee business began on May 5, 1984 in Lake Buena Vista, with preliminary plans for the 111th Annual Meeting in Hollywood. Subsequent meetings were held on September 7, 1984 in Tampa; November 16, 1984 in Orlando; and February 1, 1985 in Tampa. The Council's work is summarized under the heading of each committee and subcommittee.

Committee on Medical Education

Orris O. Rollie, M.D., Orlando, has completed a highly successful year as Chairman of the Committee. Major activities of the Committee have centered on the 111th Annual Meeting Scientific Program, ACCME accreditation of hospital continuing medical education programs, approval of Florida Medical Association mandatory credit for CME providers, and the issue of foreign medical graduates.

Subcommittee on Annual Meeting Scientific Program

Under the leadership of Ira B. Harrison, M.D., Tallahassee, the Subcommittee has again produced an outstanding scientific program for the 111th Annual Meeting in collaboration with FMA recognized specialty groups. Several highlights of the scientific program will be a symposium entitled "Quality Medicine in a Rapidly Changing Environment", and specialty programs on Bioethics and "The Basics of Searching Medline." Additional attractions will include sections on chemical dependency, workers' compensation, a special symposium on aging, Wyeth Programmed Auto Tutors, and many technical, scientific and educational exhibits.

Once again, the Annual Meeting Scientific Program will offer a total of 20 hours of AMA Category I approved continuing medical education credit. Additional co-sponsorship by the Colleges of Medicine of the University of South Florida, University of Miami, and the University of Florida will be included.

For the second year, the FMA Leadership Conference included a scientific program on Friday afternoon. World renown medical author and researcher, Robert A. Good, M.D., presented a one-hour program entitled "Clinical and Fundamental Approaches to Cellular Engineering" which was well attended and received highly favorable evaluations.

Subcommittee on Accreditation

Samuel E. Crockett, M.D., Orlando, has continued his effective leadership as Chairman of this Subcommittee. A comprehensive manual entitled *Continuing Medical Education: Essentials for Accreditation* was published and provided to every accredited organization in Florida. Interest in ACCME accreditation continues to increase and the following actions have been taken since the last Annual Meeting.

— **Baptist Medical Center,** Jacksonville — Reaccredited for a six-year period, January 13, 1984 through January 12, 1990.
— **The Good Samaritan Hospital,** West Palm Beach — Reaccredited for a six-year period, June 27, 1984 through June 26, 1990.
— **North Ridge General Hospital,** Ft. Lauderdale — Reaccredited for a six-year period, November 21, 1983 through November 20, 1989.
— **Parkway Regional Medical Center,** North Miami Beach — Reaccredited for a two-year provisional period, December 17, 1984 through December 15, 1986.
— **Sarasota County Medical Society,** Sarasota — Reaccredited for a six-year period, December 12, 1984 through December 11, 1990.
— **South Florida Psychiatric Society,** Miami — Reaccredited for a six-year period, May 25, 1983 through May 24, 1989.
— **Veterans Administration Center,** Bay Pines — Reaccredited for a two-year period, February 29, 1984 through February 28, 1986.

Subcommittee on Program Approval

Chairman David S. Hubbell, M.D., St. Petersburg, and his Subcommittee have continued to provide outstanding service to CME providers in Florida who have sought FMA mandatory credit for their programs. After programs are reviewed and approved by county medical society CME Chairmen, selected members of the Subcommittee evaluate applications and award credit if approved. In 1984, over 1300 hours of FMA mandatory credit were awarded in 380 separate programs.

Committee on Scientific Publications

Daniel B. Nunn, M.D., is completing his fifth and final year as Editor of the *Journal of the Florida Medical Association, Inc.*, and Chairman of the Committee on Scientific Publications. Since becoming Editor in June of 1980, the *Journal of the Florida Medical Association, Inc.* has published 19 special issues, 369 scientific

Reference Committee I (Health and Education) was chaired by Alvin E. Smith, M.D., Ormond Beach. Left to right: Charles J. Kahn, M.D., Pensacola; Richard G. Connar, M.D., Tampa; Douglas A. Newland, M.D., Fort Myers; Hector R. Mendez, M.D., Orlando; Miss Dawn Bouchard, Recorder; Dr. Smith; Gaston Jose Acosta-Rua, M.D., Jacksonville; Robert B. Peddy, M.D., Lakeland; Dolores A. Morgan, M.D., Miami Beach; Ernest C. Smith, M.D., Englewood.

articles, 71 special articles and 100 editorials. Included in these statistics are 873 authors. An illustration of the high quality of the JFMA during Dr. Nunn's tenure was recognition by the Sandoz Pharmaceutical Company in 1983 as the First Place Winner in the State Medical Journal Category of their Annual Medical Journalism Awards Contest.

Report of the Council on Specialty Medicine

The motion of the Reference Committee that the Report of the Council on Specialty Medicine be adopted as presented except for those portions referred to other Reference Committees carried.

The Council on Specialty Medicine held three meetings during the 1984-85 Association Year: July 21, 1984; September 29, 1984; and February 23, 1985. The Subcommittee on Recognition for Specialty Groups held meetings in conjunction with all three Council meetings.

The Council on Specialty Medicine is comprised of 38 FMA recognized specialty groups representing all major areas of medical practice. Many different issues were considered by the Council during the Association year. Major issues included:

1. **Florida Society of Ophthalmology, Inc.:** The Council recommended that the FMA approve the recommended legislative objectives submitted by the Florida Society of Ophthalmology and that they be included in the 1984-85 legislative program of the Florida Medical Association.
2. **Florida Society of Anesthesiologists:** The Council recommended that the FMA approve the recommended legislative objectives submitted by the Florida Society of Anesthesiologists and that they be included in the 1984-85 legislative program of the Florida Medical Association.
3. **Naturopathic Practice:** The Council recommended that the FMA support any legislative activities prohibiting any further licensing of naturopathic practices.
4. **House of Delegates Voting:** The Council recommended that each member of the Council on Specialty Medicine, or their designated alternate be allowed to have one vote in the FMA House of Delegates.
5. **Medicare Freeze:** The Council recommended that the FMA endorse the American Medical Association lawsuit questioning the constitutionality of the Medicare law and that the FMA urge the AMA to seek an injunction prohibiting enforcing the Medicare freeze until a federal lawsuit has been heard. The Council also recommended that FMA urge the AMA to have Congress enact a law negating the provisions of the Deficit Reduction Act pertaining to Medicare reimbursement.
6. **Licensing of Physicians:** The Council recommended that the FMA strongly oppose any legislation that would allow in special cases for physicians to bypass state licensing boards to practice medicine in Florida.
7. **Liaison Committee to PIMCO:** The Council recommended that the FMA authorize the Florida Physicians' Insurance Reciprocal Liaison Committee to conduct a thorough and detailed analysis of all existing data and reports that are available on the Reciprocal up until the time the Reciprocal was put in rehabilitation and to report its findings to the FMA membership.
8. **Terminally Ill Patients:** The Council recommended that the FMA conduct a review of all existing policies of the AMA and FMA pertaining to the withdrawal or withholding of medical care for terminally ill patients and that the highlights and legal implications of this study be directed to the attention of the FMA membership.
9. **Confidentiality of Patient Records:** The Council recommended that the FMA oppose any legislation or requests that allow for the release of confidential patient records and support the guidelines adopted by the Florida Council of District Branches of the American Psychiatric Association.
10. **Specialty Group Recognition:** The Council approved continuing recognition for the following specialty groups which have met the criteria established by the FMA House of Delegates:

    Florida Society of General Surgeons
    Florida Society of Rheumatology
    Florida Society of Clinical Oncology
    Florida Society of Dermatology
    Florida Gastroenterologic Society
    Florida Society of Neonatal Perinatologists
    Florida Society of Neurology

Florida Orthopedic Society
Florida Chapter, American Academy of Pediatrics and the Florida Pediatric Society
Florida Society of Plastic and Reconstructive Surgeons
Florida Society of Thoracic and Cardiovascular Surgeons
Florida Urological Society
Florida Society of Pathologists
Florida Endocrine Society
Florida Society of Physical Medicine and Rehabilitation

11. **Criteria for Specialty Group Recognition:** The Council recommended elimination of the recognition program criterion requiring specialty groups to participate in the FMA Annual Meeting Scientific Section once during a three year period.
12. **Mandatory Seat Belt Bill:** Upon careful study of the AMA's Council on Medical Services' report on automobile related injuries, the Council recommended the FMA endorse the Mandatory Seat Belt Bill.
13. **Massage Practice Act Bill:** The Council recommended that the FMA oppose this bill based on the fact that colonic irrigation should not be performed by non-medical personnel.
14. **Blue Ball Rat Poison:** The Council recommended that the FMA request the Commissioner of Agriculture to put more stringent regulations on the dissemination of Blue Ball Rat Poison which has caused several children to experience severe medical problems as the result of ingestion of this rodenticide.
15. **Licensing of Dieticians Bill:** The Council recommended that the FMA oppose the Licensing of Dieticians Bill.
16. **Spinal Health Month:** The Council recommended that the FMA correspond with the Governor concerning the proclamation declaring October 1984 as Spinal Health Month, in order to fully disclose some of the misleading statements made about chiropractic medicine in the proclamation.
17. **Psychiatric Benefits:** The Council recommended that the FMA require the FMIT to provide the Council with detailed hard claim data, including comparative data and actuarial projections regarding the cutting of psychiatric benefits instituted in 1982. The Council felt available data should be studied in order to properly address this issue.

Council on Specialty Medicine
Criteria for Specialty Group Recognition

1. That the organization's purpose and need not be covered by an already existing organization and must be a specialty or subspecialty recognized by the Council on Specialty Medicine;
2. That there is a sufficient number of physicians seeking the privileges of society;
3. That the organization must have held at least two annual meetings at which a quorum was present prior to the time of application, and must continue to have an annual meeting each subsequent year of recognition;
4. That a constitution and/or bylaws state its organizational structure, purpose and aims;
5. That the membership will abide by the "Principles of Medical Ethics" of the FMA and AMA;
6. That the organization provide continuing medical education to its members;
7. That the organization have statewide representation;
8. That 100% of the active eligible members shall be members of the FMA (a 10% variation may be allowed by the Board of Governors);
9. That the attendance record of the Council representative will be considered at the time of recognition;
10. That specialty groups be required to participate in the Florida Medical Association Annual Meeting at least once every three years;
11. That participation in joint scientific sections at the FMA Annual Meeting qualify the participating specialty groups as meeting this criteria;
12. That the Council on Specialty Medicine monitor the FMA-recognized specialty groups to insure this criteria is being met; and
13. That FMA specialty groups are still required to meet the continuing medical education requirements in recognition.

Report A of the Board of Governors

The Reference Committee recognized Daniel B. Nunn, M.D., Editor, *The Journal of the Florida Medical Association, Inc.*, from May of 1980 to May of 1985, for his superb contributions of the scientific publications and medical information available to the membership during his tenure.

Report A of the Board of Governors was adopted as presented except for those portions referred to other Reference Committees, and that special attention be given to the Prescription Abuse Data Synthesis (PADS) Program with information being disseminated to the membership concerning this program.

Recommendation No. G-1 was adopted as presented.

Recommendation No. G-2 was adopted as presented.

Report A of the Board of Governors
Frank C. Coleman, M.D.

Board Actions of Major Importance

FMA Councils and Committees

COUNCIL ON SCIENTIFIC ACTIVITIES

The Annual Report of the major activities of the Council on Scientific Activities is included in this section of the Delegates' Handbook. The Board of Governors has reviewed the Council's activities during the past Association year and submits the following report and/or recommendations to the House regarding each of the items addressed by the Council.

1985 Annual Meeting: The Board established the format for the 1985 Annual Meeting, May 1-5 at the Diplomat Hotel in Hollywood, Florida, and approved a scientific theme, "Quality Medicine in a Rapidly Changing Enviornment." The Board approved a symposium on this timely subject to be held on Thursday, May 2 from 4:00 p.m.-5:00 p.m. and requested that no other activities be scheduled at that time. It is expected that some 22 specialty societies will participate in the scientific sections and FMA members can earn up to 20 hours AMA Category I continuing medical education credit.

PADS Symposium: The Board of Governors approved FMA co-sponsorship of the PADS Symposium by the University of South Florida and the AMA.

CME Reporting: The Board requested the Council to reexamine the process of CME reporting and the need to involve county medical societies.

CME Research Project: The Board approved FMA support and participation in a nationwide study of the status of continuing medical education being conducted by The Society of Medical College Directors of CME.

FMA Journal Editor: The Board expressed its highest commendations and appreciation to Daniel B. Nunn, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, and Chairman of the Committee on Scientific Publications for his superb contributions and efforts as Editor of *The Journal* for the past five years.

The Board approved the President-Elect's selection of Remigio G. Lacsamana, M.D., Daytona, as Dr. Nunn's successor to serve as Editor of *The Journal* for the Association year 1985-86.

COUNCIL ON SPECIALTY MEDICINE

The Annual Report of the major activities of the Council on Specialty Medicine is included in this section of the Delegates Handbook. The Board has reviewed the Council's activities during the past Association year and submits the following report and/or recommendations to the House regarding each of the items addressed by the Council.

Specialty Society Legislative Programs: The Board approved the recommended legislative objectives for the Florida Society of Ophthalmology and referred these to the Council on Legislation for consideration of the appropriate category of FMA support, including the defeat of any legislation that would authorize optometrists to use or prescribe legend drugs in the diagnosis or treatment of medical problems of the eye, opposition to legislation that would authorize optometrists hospital staff privileges, and opposition to any legislation that attempts to change the present law allowing medical examiners to remove corneal tissue under certain conditions.

The Board approved the recommended legislative objectives of the Florida Society of Anesthesiologists and referred these to the Council on Legislation for determination of the appropriate category of FMA support, including legislation that would ensure that certified registered nurse anesthetists be supervised by a physician or preferably be medically directed by an anesthesiologist; ensure that staff privileges are not mandated for nurse anesthetists; opposition to any legislation which would permit dentists to give anesthesia for non-dental procedures; and continue efforts to pass meaningful tort reform.

Naturopathic Practice: The Board expressed support for legislation prohibiting any further licensing of naturopathic practice.

Confidentiality of Patient Records: The Board expressed opposition to any legislation or request that would allow for the release of the confidential portion of patient medical records.

Licensing of Physicians: The Board reaffirmed the FMA's opposition to any legislation that would allow in special cases for physicians to bypass state licensing boards to practice medicine in Florida, and referred this to the Council on Legislation for appropriate action.

Specialty Group Recognition: The Board approved continuing recognition for the following specialty groups who have met the criteria established by the FMA House of Delegates for recognition by the Association: (Appendix A-1)

Florida Society of Clinical Oncologists
Florida Society of Dermatology
Florida Gastroenterologic Society
Florida Society of Neonatal-Perinatologists
Florida Society of Neurology
Florida Orthopedic Society
Florida Chapter, American Academy of Pediatrics and the Florida Pediatric Society
Florida Society of Plastic and Reconstructive Surgeons
Florida Society of Thoracic and Cardiovascular Surgeons
Florida Urological Society
Florida Society of General Surgeons
Florida Society of Rheumatology
Florida Society of Pathologists
Florida Endocrine Society
Florida Society of Physical Medicine and Rehabilitation

The Board authorized a 60-day grace period beginning February 23 and ending April 30, 1985 to the following specialty groups who have greater than a 10% variation in non-FMA members and who are actively seeking compliance from their members:

Florida Society of Anesthesiologists
Florida Occupational Medical Association
Council of Florida District Branches of the American Psychiatric Association

The action taken regarding these specialty societies will be included in a Supplemental Report of the Council to the House of Delegates. The Florida Association of Nuclear Physicians was placed on one year probation for not having met all the criteria for continuing recognition by the FMA.

Recognition Criteria: The Board disapproved a recommendation that FMA eliminate the requirement that specialty groups participate in the scientific section of the FMA Annual Meeting at least once every three years.

Specialty Group Representation in the House of Delegates: The Board determined that the FMA Board of Governors recommend to the House of Delegates for consideration at its next Annual Meeting that each member of the Council on Specialty Medicine or their alternate be allowed one vote in the FMA House of Delegates. (Please refer to Board Report C, [blue], Reference Committee III in the Delegates Handbook.)

Medicare Freeze: The Board endorsed the American Medical Association's action regarding the Deficit Reduction Act and Medicare freeze by asking physicians to voluntarily freeze their fees under Medicare for one year.

Terminally Ill Patients: The Board requested the FMA Judicial Council to conduct an indepth study of all existing policies of the FMA and AMA pertaining to the withdrawal or withholding of medical care for the terminally ill patient, and that a summary and any legal implications of this study be transmitted to the FMA membership.

Motorcycle Helmets: The Board expressed opposition to any legislation that would allow motorcycle operators and passengers not to wear protective head gear, and referred this action to the Council on Legislation.

Massage Practice: The Board expressed opposition to legislation that would allow licensed massage therapists to perform colonic irrigation, and referred this action to the Council on Legislation.

Rat Poison: The Board recommended to the Commissioner of Agriculture that "Blue Ball Rat Poison" and all other similarly dangerous compounds be banned or distributed in a tightly controlled manner with appropriate packaging in order to prevent children from ingesting these compounds.

Governor's Proclamation Regarding Chiropractic: The Board advised the Governor of the FMA's concern regarding the proclamation he issued on chiripractic which states, "The science of chiropractic and the doctors who practice it have contributed greatly to the better health of our citizens by providing this specialized health care."

Report G
Supplement to Report A
of the
Board of Governors

Report G, Supplement to Report A, of the Board of Governors was adopted.

Report G
Supplement of Report A
of the
Board of Governors
Frank C. Coleman, M.D.

The Board of Governors authorized a 60-day grace period beginning February 23, and ending April 30, 1985, to three specialty groups who have greater than a 10% variation in non-FMA members and who are actively seeking compliance from their members.

Since the time period has expired, the Florida Society of Anesthesiologists have met all criteria to be recognized as a member on the Council of Specialty Medicine.

Two other specialty groups did not meet the membership criteria during the 60-day grace period and, therefore, were recommended to be placed on a one year probation.

RECOMMENDATION NO. G-1

THAT CONTINUING RECOGNITION BE GRANTED TO THE FLORIDA SOCIETY OF ANESTHESIOLOGISTS WHICH HAS MET THE CRITERIA ESTABLISHED BY THE HOUSE OF DELEGATES FOR RECOGNITION BY THE ASSOCIATION.

RECOMMENDATION NO. G-2

THAT THE FOLLOWING SPECIALTY GROUPS WHO HAVE NOT MET ALL THE CRITERIA ESTABLISHED BY THE HOUSE OF DELEGATES FOR RECOGNITION BY THE ASSOCIATION BE PLACED ON A ONE-YEAR PROBATION:

Florida Occupational Medical Association
Council of Florida District Branches of the
American Psychiatric Association

RESOLUTION 85-20
Continuing Medical Education
Hillsborough County Medical Association

Resolution 85-20 was not adopted.

The Reference Committee observed that most of the testimony at the meeting by the attendees indicated that CME requirements of the FMA should continue to be enforced.

The Reference Committee expressed its appreciation to all members of the Association who appeared at their meeting to provide guidance and counsel.

Special thanks was conveyed to Richard G. Connar, M.D., who represented the AMA Delegates at the meeting of the Reference Committee. The Chairman expressed his sincere appreciation to members of the Committee: Gaston Jose Acosta-Rua, M.D.; Robert B. Peddy, M.D.; Hector R. Mendez, M.D.; Dolores A. Morgan, M.D.; Ernest C. Smith Jr., M.D.; Douglas A. Newland, M.D.; and Charles J. Kahn, M.D.(AMA Alternate). The Reference Committee also thanked FMA staff Dr. Robert C. Fore and Ms. Dawn Bouchard for their assistance in the preparation of the Report.

The motion of the Reference Committee that the Report of Reference Committee No. I, Health and Education, be adopted as amended carried.

Report of Reference Committee No. II Public Policy

Dr. Perry called the Chairman and members of Reference Committee No. II, Public Policy, to present their Report.

Dr. Luis R. Guerrero, Chairman, and his Committee came forward to present the Report of Reference Committee No. II, Public Policy.

Report of the Council on Medical Services

The motion of the Reference Committee that the Report of the Council on Medical Services be adopted as printed in the Handbook carried.

Council on Medical Services

Joseph T. Ostroski, M.D., Chairman

The creation of a sixth component committee, the Committee on Health Manpower, helped make 1984-85 an extremely active year for the Council on Medical Services. The Council met twice, September 16, 1984, and February 8, 1985, to review the work of the Committee on Aging, the Committee on Health Manpower, the Committee on Emergency Medical Services, the Committee on Public Health, the Committee on School Health and the Committee on Substance Abuse.

Recommendations of the Council and its committees have been submitted to the Board of Governors from time to time during the year, and the following is a general summary of their activities.

Committee on Aging

The Committee on Aging, ably headed this year by Clyde M. Collins, M.D., of Jacksonville, met only once, but it has been deeply involved in carrying out, in cooperation with the FMA Auxiliary, a public relations and education project concerning Florida's senior citizens.

A major element in this project has been the development, printing and distribution of "Medi-File", a wallet-size card for senior citizens. Purpose of the card is to provide a personal registry for all prescription drugs being taken by the carrier, allergies, and other medical information.

Hundreds of physicians have requested supplies of "Medi-File" for their patients, and three printings totalling 500,000 copies have been authorized to date. In addition, a Spanish language version is under consideration.

A newspaper column entitled "Health Notes for Older Adults" is being distributed on a monthly basis. So far subjects have included "Exercise", "Osteoporosis", "Drugs", and "Recipe for '85". The column is being sent to various publications targeted to senior citizens as well as to FMA's regular mailing list of newspapers and magazines.

Another major project of the Committee this year is the planning and presentation of a "Symposium on the Care of the Aging Patient" at the 1985 FMA Meeting. Speakers will include: John C. Beck, M.D., Director of the UCLA/USC Long-Term Care Gerontology Center, Los Angeles, California; George J. Caranasos, M.D., University of Florida College of Medicine, Gainesville; Eric Pfeiffer, M.D., University of South Florida College of Medicine, Tampa; and Steven Sevush, M.D., University of Miami School of Medicine, Miami.

Committee on Emergency Medical Services

The Committee on Emergency Medical Services, competently directed by Daniel E. Lucas, M.D., of Stuart, has met twice this year. Its major project has been the development of effective trauma center legislation in cooperation with the Florida Office of Emergency Medical Services, the FMA Council on Legislation, and other interested groups. The EMS Committee, working with the State EMS Advisory Council, will submit legislation that will seek to establish designation, regionalization and categorization of trauma centers in Florida.

In support of this endeavor, the Committee developed and distributed during September and October an attractive media kit consisting of journal articles written by nationally known authorities on trauma and excerpts from the Florida Medical Foundation's *EMS Project Report*.

The Committee also has been interested in the expansion of the 911 emergency telephone number into areas which do not already have it, and state-of-the-art poison control centers.

In addition, the Committee has reviewed and commented upon various administrative rules covering ambulances and other aspects of emergency care proposed by the Florida Office of Emergency Medical Services.

Committee on School Health

The affairs of the Committee on School Health have been effectively administered by Bernard Kimmel, M.D., of West Palm Beach, who last November was elected to the Florida House of Representatives. At the time this report was prepared, the Committee had met three times during 1984-85 and had a fourth session planned for April in conjunction with the School Health Conference in Tampa.

Perhaps the Committee's greatest area of concern has been a 1984 amendment to Chapter 232, Florida Statutes, which is being interpreted to permit chiropractors and other limited care practitioners to perform pre-school health examinations. Appropriate recommendations in this area have been addressed to the Board of Governors.

As the School Health Medical Advisory Committee to the Department of Education and the Department of Health and Rehabilitative Services, the Committee has reviewed and approved: standards for clean intermittent catheterization; standards for emergency first aid procedures for insect sting reactions; contents of school bus first aid kits; and school bus driver application forms and examinations.

The Committee is in the process of developing a communicable diseases document for use by nurses, teachers and other school personnel. The document will summarize the more common communicable diseases and provide information on incubation periods, periods of communicability and recommendations as to when a diseased student should be excluded from and readmitted to school. Among other things, the document will address the sensitive areas of sexually transmitted diseases and Acquired Immune Deficiency Syndrome (AIDS). The Committee is most grateful to State Epidemiologist Jeffrey Sacks, M.D., for his help in developing this document.

In the area of substance abuse, the Committee has developed and forwarded to the Board of Governors, through this Council, appropriate recommendations concerning drug education from kindergarten through high school.

For several years the Committee has been attempting to develop a model pre-participation physical examination form, a subject that has fomented some debate in reference committees of the House of Delegates for the past two years. Instead of once again recommending universal adoption of a specific form, the Committee has cited forms in use in the Duval County School system as prototypes; developed a checklist for school systems which wish to develop their own forms; and volunteered to review any new forms developed for completeness and adequacy.

Committee on Health Manpower

Daniel Seckinger, M.D., of Miami, has been extremely effective in the first year's operation of the new Committee on Health Manpower. The Committee has met twice to tend to the many tasks assigned to it by the FMA Board of Governors.

One of the major areas attracting the Committee's attention has been the problem of foreign medical graduates, particularly American citizens who have studied at the so-called "off-shore medical schools". One of the Committee's meetings was devoted almost exclusively to this issue. The Committee has reviewed the various legislative proposals of the Florida Department of Professional Regulation to contain this problem from a licensure standpoint and has forwarded its recommendations to the Board of Governors through the Council.

The Committee has been charged with responsibility for monitoring the legislative activities of allied health groups which seek to expand their scope of practice. One such group is the pharmacists who once again are asking the Legislature to invest them with limited drug prescription privileges. In this area, too, the Committee has made recommendations.

At the present time, the Committee is assembling a list of physicians representing each FMA recognized specialty group who can be called upon to testify before legislative committees on medically related issues, including health manpower. The Committee hopes to complete this roster before the opening of the 1985 Florida Legislature.

One other major project of the Committee has been to attempt to determine areas of shortage and oversupply of the various medical and surgical specialties within Florida. The first effort to assemble this information through query to the national specialty groups corresponding to the boarded specialties was not especially successful.

Some have indicated they have made no manpower studies, and the information received from most of the others was too general to be of great use in making intrastate regional determinations. Other approaches are being made to obtain this information.

Committee on Substance Abuse

The Committee on Substance Abuse has been capably chaired by Joseph H. Deatsch, M.D., of Jacksonville. The Committee has met once, and has been active in a number of areas, including participation in the work of the Governor's Task Force on Alcohol and Drug Concerns; and the Florida Prescription Abuse Data Synthesis (PADS) project committee.

In addition, the Committee assisted with the planning of Florida's first Statewide Conference on Prescription Drug Abuse and Misuse in Tampa in October, 1984; and the Southeastern Conference on Prescription Drug Abuse, which will be conducted in Charleston, S.C., in May 1985.

In the near future, the Committee plans to begin work on a drug reeducation curriculum for physicians.

Committee on Public Health

Robert D. May, M.D., of New Port Richey, has provided able leadership to the Committee on Public Health which, at the time this report was prepared, had conducted two meetings and planned a third for March.

In order to process its heavy workload, the Committee has been organized into subcommittees on governmental regulations; legislative study; education and public relations; and environmental health and consumer protection. The bulk of the workload of these subcommittees is handled by mail or telephone.

The Committee's effectiveness also has been enhanced by the addition of an obstetrician-gynecologist and a family physician to the Committee's roster, as well as prominent academicians in public health or related disciplines from the University of Miami, the University of Florida and the University of South Florida, who have been appointed as advisory members.

The Committee on Public Health has considered and drafted recommendations on a variety of public health matters including: septic tanks in industrial parks; sexually transmitted diseases laws; permitting inland bodies of water as bathing places; fluoridation of public water supplies; Florida's primary care initiative and others.

Report B of the Board of Governors

The Reference Committee commended the Board of Governors for its outstanding performance during the year.

A motion of the Reference Committee carried to adopt Recommendation No. B-1 as amended.

Report B of the Board of Governors was adopted as amended except for those portions referred to other Reference Committees.

Recommendation No. B-2 was adopted.

Recommendation No. B-3 was adopted.

Report B of the Board of Governors

Frank C. Coleman, M.D., Chairman

Board Actions of Major Importance

FMA Councils and Committees

COUNCIL ON MEDICAL SERVICES

The Annual Report on the major activities of the Council on Medical Services is included in this section of the Delegates Handbook. The Board has reviewed the Council's activities during the past Association year and submits the following report and/or rec-

Reference Committee II (Public Policy) was chaired by Luis R. Guerrero, M.D., Palm Beach Gardens. Left to right: Peter A. Tomasello, M.D., Plantation; Charles S. Eytel, M.D., Naples; Harold G. Norman, M.D., Coral Gables; Joseph T. Ostroski, M.D., Miami; not pictured Ms. Anita Suddeth, Recorder. Standing Dr. Guerrero; Robert E. Windom, M.D., Sarasota; Wallace M. Philips Jr., M.D., Orlando; Michael R. Redmond, M.D., Pensacola; John W. Glotfelty, M.D., Lakeland.

ommendations to the House regarding each of the items addressed by the Council.

National Conference on Long Term Care For the Elderly: The Board approved FMA endorsement and participation in a national conference on implementing community based long term care for the elderly, to be presented in Miami Jewish Home and Hospital for the Aged and the Area Agency on Aging of Dade and Monroe County. The Board requested that the Dade County Medical Association, the Monroe County Medical Society and their respective auxiliaries be consulted in the planning process.

Symposium on Care of the Elderly: The Board approved the concept of a "Symposium on Care for the Elderly Patient" to be held in conjunction with the 1985 FMA Annual Meeting.

Committee on Health Manpower: The Board adopted as goals for the Committee on Health Manpower:

Identify those allied health groups that anticipate expanded activity through legislation or regulatory means;

If possible, identify the goals of each allied health group;

Develop an adequate data base for use by FMA, the staff and communicating with allied health groups;

Develop a data base on physician manpower in Florida with identification of areas of shortages and what steps are being taken to correct these shortages;

Develop a roster of expert witnesses who will be available upon short notice to represent FMA at legislative hearings;

Cooperate with other agencies and groups to resolve problems with foreign trained health professionals.

"Medi-File" Card: The Board approved sending a copy of the "Medi-File" card to each FMA member with a letter explaining its purpose and use. The "Medi-File" card is a public relations and education program for the elderly developed in cooperation with the FMA Auxiliary to provide an easily accessible way of recording information on prescription drugs being taken by patients over 65 years of age. The Board also authorized that the "Medi-File" card be published in Spanish.

Primary Care Program Initiative: The Board urged the Department of Health and Rehabilitative Services to continue its flexible policy in the evaluation of grants under the primary care program initiative (Laws of Florida 84-35) and further, of the importance of involving the private practice community and educational institutions in the development of primary care program initiative.

EMS Legislation: The Board approved and referred to the Council on Legislation for determination of the appropriate level of FMA support the recommendation that FMA seek the enactment of EMS legislation that will establish the concept of regional designated trauma centers in Florida, create an up-to-date system of poison control centers and encourage statewide implementation of the 911 emergency telephone system.

Health Manpower Shortage Areas: The Board reviewed proposed procedures for evaluating designated health manpower shortage areas that would put FMA in a better position to respond within the 30 day period allowed by the Department of Health & Human Services.

RECOMMENDATION NO. B-1

HEALTH MANPOWER SHORTAGES: THAT THE HOUSE OF DELEGATES APPROVE THE ADOPTION OF THE FOLLOWING PROCEDURE FOR REVIEW AND COMMENTS ON PROPOSED DESIGNATIONS OF HEALTH MANPOWER SHORTAGE AREAS IN FLORIDA REFERRED TO THE FMA BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES:

1. THE REQUEST FOR COMMENT, ALONG WITH THE ORIGINAL APPLICATION AND OTHER SUPPORTING PAPERS SUPPLIED BY HHS, UPON RECEIPT BY THE FMA WILL BE FORWARDED IMMEDIATELY TO THE SECRETARY OF THE APPROPRIATE COUNTY MEDICAL SOCIETY.

2. THE MATERIAL WILL BE ACCOMPANIED BY A LETTER FROM THE COMMITTEE ON HEALTH MANPOWER REQUESTING THE COUNTY MEDICAL SOCIETY TO RESPOND DIRECTLY TO FLORIDA MEDICAL ASSOCIATION WITH A COPY SENT TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

3. IN THE CASE OF PROPOSED DESIGNATIONS INVOLVING DENTAL SERVICES, THE FLORIDA DENTAL ASSOCIATION WILL BE PROVIDED WITH COPIES OF ALL CORRESPONDENCE SIMULTANEOUSLY.

4. **THE FMA HEADQUARTERS WILL MAINTAIN A FILE ON ALL PROPOSED DESIGNATIONS, AND THE ESSENTIAL COMPONENTS OF ALL CASES WILL BE REPORTED FROM TIME TO TIME TO THE COMMITTEE ON HEALTH MANPOWER AND THE COUNCIL ON MEDICAL SERVICES.**

School Entry Health Examinations: The Board directed that the Department of Health and Rehabilitative Services be advised that the FMA strongly objects to the interpretation of Section 232.0315, Florida Statutes, which authorizes chiropractors to perform school entry health examinations, and supported the policy that all such examinations be completed by a licensed Doctor of Medicine or Doctor of Osteopathy.

Fingerprinting of Children: The Board endorsed programs of voluntary fingerprinting of children as an aid in identifying missing persons.

Child Abuse: The Board encouraged the FMA membership to participate in promoting recognition of, and education concerning, child abuse in both family and institutional settings.

Methadone Programs: The Board urged the Florida Department of Health and Rehabilitative Services to employ a knowledgeable and qualified individual to monitor compliance with, and exceptions to, the 1984 regulations governing methadone treatment programs.

Prescription Abuse Date Synthesis Project (PADS): The Board recommended to the Department of Professional Regulation that it look into the possibility of deputizing members of the triage committee provided for under the FMA's policy on drug diversion identification and intervention.

Legislation of Heroin: The Board expressed strong opposition to the legalization of heroin as proposed in HB 5290 for use in controlling pain for terminal patients.

Dupont Pharmaceuticals: The Board commended Dupont Pharmaceuticals for its current campaign to alert pharmacists to the potential for drug diversion through fraudulent prescriptions.

Physician Responsibility Re: Prescription Drugs: The Board requested that FMA members be reminded of their responsibility to cooperate fully with pharmacists in ascertaining the legitimacy of individual prescriptions whether ordered by verbal or written means, and to verify these prescriptions with the pharmacist personally whenever possible.

Drug Diversion Education: The Board authorized the Council on Scientific Activities to assist the Committee on Substance Abuse in forming a work group of physicians that would identify needs, set goals and plan curricula for the education and reeducation of physicians in the areas of prescription drugs and prescription drug diversion.

National Commission on Correctional Health Care: The Board endorsed the program of the National Commission on Correctional Health Care for accreditation research and training in correctional health care. The Commission, which includes representatives of several national medical and health organizations including the AMA, plans to continue the jail health care accreditation program begun by the AMA several years ago.

Environmental Hazards: The Board expressed support for legislation to expand Chapter 381, Florida Statutes, to include reporting of diseases (Morbidity and Mortality) related to environmental hazards.

Occupational Disease: The Board approved the FMA support for institution of an occupational health program at the state level within the Health Program Office to assess the magnitude of occupational disease in Florida.

Hepatitis B: The Board supported the development of a policy on management of Hepatitis B in state institutions and among clients and employees of the Florida Department of Health and Rehabilitative Services to be transmitted to the Health Program Office of HRS.

Public Health - Public Relations Program: The Board approved an FMA public health education program directed at the general public and the medical profession; and further, that this program be accomplished through the production and distribution of radio and television public service announcements addressing such themes as driving and drinking, use of drugs, automobile safety belts and smoking.

Septic Tanks in Industrial Parks: The Board urged the Health Program Office to insure that septic tanks in industrial parks will not be used for disposal of toxic or hazardous chemicals.

Substance Abuse and Chemical Education K through 12:

RECOMMENDATION NO. B-2

THAT THE HOUSE OF DELEGATES ADOPT THE FOLLOWING FMA POSITION WITH REGARD TO SUBSTANCE AND CHEMICAL ABUSE EDUCATION IN FLORIDA SCHOOLS UP TO GRADE 12:

1. **URGE THE LEGISLATURE TO PLACE MORE EMPHASIS ON THE TEACHING OF HEALTH EDUCATION, INCLUDING SUBSTANCE ABUSE, IN THE ELEMENTARY, MIDDLE SCHOOLS, AND HIGH SCHOOLS.**
2. **RECOMMEND TO THE LEGISLATURE THAT SECTION 230.2319, FLORIDA STATUTES, KNOWN AS FLORIDA PROGRESS IN MIDDLE CHILDHOOD EDUCATION PROGRAM (PRIME) BE AMENDED TO MANDATE THE TEACHING OF HEALTH EDUCATION, INCLUDING SUBSTANCE ABUSE, STRESS MANAGEMENT AND EMOTIONAL HEALTH IN GRADES 4 THROUGH 5 THROUGH 8. AS IT CURRENTLY EXISTS, THIS LAW PROVIDES ONLY LIMITED HEALTH EDUCATION IN MIDDLE GRADES.**
3. **RECOMMEND TO THE LEGISLATURE THAT TEACHER CERTIFICATION REQUIREMENTS INCLUDE AN INDEPTH COURSE IN HEALTH EDUCATION AND SUBSTANCE ABUSE. THE MAIN FOCUS OF THE CURRICULUM SHOULD BE ON PREVENTION, BUT IT SHOULD ALSO INCLUDE IDENTIFICATION OF THE SIGNS AND SYMPTOMS OF SUBSTANCE ABUSE AND THE PROCEDURES FOR INTERVENTION WITH STUDENTS AND THEIR FAMILIES.**
4. **COMMENDED THE LEGISLATURE FOR PASSAGE OF THE REQUIRED ONE SEMESTER LIFE MANAGEMENT SKILLS COURSE TO BE TAKEN IN THE 9TH OR 10TH GRADE. THE LEGISLATURE SHOULD BE ALERTED TO THE FACT THAT THIS IS THE LAST TIME STUDENTS WILL BE INVOLVED IN HEALTH EDUCATION AND SUBSTANCE ABUSE COURSES. IT WOULD BE OF VALUE TO STUDENTS IF AN ADDITIONAL COURSE AT THE 11TH AND 12TH GRADE LEVEL WOULD BE REQUIRED SINCE THE QUALITY OF LIFE IS SO DEPENDENT ON AN INDIVIDUAL'S HEALTH.**
5. **RECOMMEND TO THE LEGISLATURE CONTINUED CATEGORICAL FUNDING FOR COMPREHENSIVE HEALTH EDUCATION.**

Hand Washing Facilities in the Schools: The Board recommended to the Florida Department of Education that proper hand washing by school students is one act of personal hygiene that can reduce the spread of many communicable diseases in the school setting, and further, urged the Department to adopt requirements for new school construction that will assure the installation of adequate numbers of conveniently located sinks for hand washing.

Isolete Cell Antibody - Diabetes Study: The Board reaffirmed FMA endorsement of research being conducted at the University of Florida by Knoll K. Maclaren, M.D., and others, entitled "Isolete Cell and Autoantibodies and Natural History of IDD."

Witnesses: The Board determined that each FMA recognized specialty groups be requested through the Council on Specialty Medicine to nominate five (5) of its members who would be willing to testify as necessary on behalf of FMA before legislative committees on all health related issues, including health manpower.

Florida High School Activities Form: The Board approved the recommendation that health history and interval health history and physical examination forms such as those used in Duval County public schools be used as a prototype for health examination forms in other counties; and, further, that if the County School Boards wish to develop their own health examination form, the Florida Medical Association School Health Medical Advisory Committee would volunteer to review them for adequacy and completeness in accordance with guidelines developed by the Committee. (To be included in the Delegates' Notebook.)

Participating Physical: The House of Delegates at its 1984 meeting, approved Recommendation No. B-3 of the Council on Medical Services regarding preparticipation physicals:

> That the House of Delegates recommend to the Florida High School Activities Association that preparticipation physicals be required once at the entry of junior high school level and once at the entry of high school level with annual updated histories on a yearly basis.

RECOMMENDATION NO. B-3

THAT THE HOUSE OF DELEGATES APPROVE THE ADOPTION OF THE FOLLOWING AMENDED POLICY OF THE FMA REGARDING PREPARTICIPATION PHYSICALS:

"THAT THE HOUSE OF DELEGATES RECOMMEND TO THE FLORIDA HIGH SCHOOL ACTIVITIES COMMISSION THAT PREPARTICIPATION PHYSICALS BE REQUIRED ONCE AT THE ENTRY OF JUNIOR HIGH SCHOOL LEVEL AND ONCE AT THE ENTRY OF HIGH SCHOOL LEVEL WITH ANNUAL UP-DATED HISTORIES THEREAFTER, AND REPEAT PHYSICALS AS INDICATED.

Prison Medical Services In Florida: The Board authorized the FMA, in conjunction with the Florida Department of Health and Rehabilitative Services (HRS), propose to the Florida Legislature that funds be provided, through HRS, to the Florida Medical Foundation for:

1. Evaluation of the current jail medical care system in Florida;
2. Formulation of recommendations for meeting AMA recognized standards; and
3. Provision of expertise and in impetus for localities to implement accredited programming.

Fluoridation of Public Water Supplies: The Board reiterated the FMA's support for fluoridation of public water supplies in Florida.

Samuel Rowley, M.D. - Retirement: The Board took official notice of the impending retirement of Samuel Rowley, M.D., from the position of Public Health Director of Duval County. The Board, in behalf of FMA , wishes to commend Dr. Rowley for the many contributions he has made to public health in that position and as a member of the FMA Committee on Public Health.

RESOLUTION 85-11
Organ Harvesting
Dade County Medical Association

The motion for the Reference Committee to amend the "Resolved" portion of the Resolution to read as follows:

"RESOLVED, That the Florida Medical Association, through its membership, does endorse organ donation as an appropriate and meaningful experience for the recipients and the grieving families; and be it further

RESOLVED, That FMA members should encourage hospital involvement in the maintenance of the potential organ donor as the ultimate life-saving opportunity for those who suffer from end-stage organ failure; and be it further

RESOLVED, That the Florida Medical Association encourage its members to assist the transplant programs in their efforts to procure donated organs for transplantation and thus become integral members of the "transplant team" in its life-saving efforts; and be it further

RESOLVED, That the FMA Board of Governors evaluate the need for and, if appropriate, pursue proper legislation to implement this program."

Resolution 85-11 was adopted as amended.

RESOLUTION 85-11
Organ Harvesting

"RESOLVED, That the Florida Medical Association, through its membership, does endorse organ donation as an appropriate and meaningful experience for the recipients and the grieving families; and be it further

RESOLVED, That FMA members should encourage hospital involvement in the maintenance of the potential organ donor as the ultimate life-saving opportunity for those who suffer from end-stage organ failure; and be it further

RESOLVED, That the Florida Medical Association encourage its members to assist the transplant programs in their efforts to procure donated organs for transplantation and thus become integral members of the "transplant team" in its life-saving efforts; and be it further

RESOLVED, That the FMA Board of Governors evaluate the need for and, if appropriate, pursue proper legislation to implement this program."

RESOLUTION 85-17
All Terraine Vehicle (ATV) Injuries
Collier County Medical Society

The motion of the Reference Committee that Resolution 85-17 be adopted and referred to the Board of Governors for determination of fiscal impact with the editorial change of deleting "three-wheel" from the first line was carried.

RESOLUTION 85-17

All Terraine Vehicle (ATV) Injuries

(Adopted — Referred to Board of Governors)

Whereas, All terraine vehicles (ATVs) are recreational motor vehicles which are becoming more popular nationally and in Florida particularly (260% since 1982)*; and

Whereas, The number of emergency room ATV related injuries has increased 800% and related deaths 300%*; and

Whereas, Almost three-fourths of the victims were between the ages of five and twenty-four*; and

Whereas, The main problems seen in the majority of ATV accidents are instability and difficulty of control*; and

Whereas, The U.S. Consumer Product Safety Commission recommends active state and local education programs concerning the dangers of these recreational vehicles; and

Whereas, Public health and safety education is a proper function of organized medicine; therefore be it

RESOLVED, That the FMA undertake a strong campaign to educate the public regarding the serious dangers of all terraine vehicles (ATVs) through the electronic and printed media as well as programs in the schools.

*U.S. Government Memorandum; Update of Actions on All Terraine Vehicles, February 20, 1985. U.S. Consumer Product Safety Commission.

RESOLUTION 85-23
Pre-School Physical Examinations
Duval County Medical Society

Resolution 85-23 was adopted.

RESOLUTION 85-23
Pre-School Physical Examinations

RESOLVED, That the Florida Medical Association opposes the performance of pre-school health examinations by chiropractors and other limited care practitioners as being contrary to the best interests of the school children of Florida; and be it further

RESOLVED, That the Florida Medical Association believes that the pre-school examination is of such importance to the health and well-being of children that only an examination and certification performed and signed by a qualified Doctor of Medicine or Doctor of Osteopathy should be accepted by local boards of education; and be it further

RESOLVED, That the Florida Medical Association work with its county medical societies and recognized specialty groups, the Florida Osteopathic Medical Association, state government agencies and local school boards to develop programs that will make a pre-school examination by a qualified practitioner available to every school child; and be it further

RESOLVED, That the Florida Medical Association adopt as part of its legislative program further amendment to Section 232.0315(1), Florida Statutes, to specify that local school boards may accept health certifications signed only by physicians licensed or as defined in Chapter 458 and Chapter 459, Florida Statutes.

The Reference Committee expressed its appreciation to all members of the Association who appeared at their meeting to provide guidance and counsel, and to Dr. Joseph T. Ostroski, Chairman of the Council on Medical Services.

Special thanks were conveyed to Robert E. Windom, M.D., and Joseph T. Ostroski, M.D., the AMA Delegates at the meeting of this Reference Committee. The Chairman expressed his sincere appreciation to members of the Committee: Doctors Michael R. Redmond, Charles S. Eytel, Wallace M. Philips Jr., Harold G. Norman, John W. Glotfelty and Paul A. Flaten.

The Reference Committee thanked FMA staff, Mr. Edward D. Hagan, Ms. Anita Suddeth and Mr. Don Weidner, Associate General Counsel, for their assistance in the preparation of this Report.

The motion of the Reference Committee that the report of Reference Committee No. II, Public Policy, be adopted as amended carried.

EMERGENCY RESOLUTION
Public Health Committee and the
Preventive Medicine Society

A motion from the floor carried to adopt as amended an Emergency Resolution as presented by Dr. Joseph T. Ostroski, Dade County.

EMERGENCY RESOLUTION

Whereas, The basic science of public health is epidemiology; and

Whereas, a basic function of public health action programming is communicable disease control; and

Whereas, epidemiology and communicable disease control has been and continues to be among the most important aspects of government action in public health; and

Whereas, the State Department of Health and Rehabilitative Services does not have an established position for the provision of epidemiologic work in Florida; and

Whereas, the Department of Health and Rehabilitative Services has looked to the Federal Government for assignment to Florida of epidemiologists for many years; and

Whereas, the Florida Society for Preventive Medicine, the specialty organization for public health of the Florida Medical Association, emphasizes the importance of a state epidemiologist

Whereas, the current assignee is leaving in June and no new assignee will be designated because of the absence of an established postition; therefore be it

RESOLVED, That the Florida Medical Association request and urge the Governor, the President of the Senate, the Speaker of the House and the Secretary of the Department of HRS to immediately establish and budget for a position of state epidemiologist and that recruitment for a qualified physician-epidemiologist licensed in the State of Florida be initiated immediately so that protection of the public's health against epidemic disease may be assured.

Report of Reference Committee No. III Finance and Administration

Dr. Perry called the Chairman and members of Reference Committee No. III, Finance and Administration, to present their Report.

Dr. Margaret C.S. Skinner, Chairman, and her Committee came forward to present the report of Reference Committee No. III, Finance and Administration.

Remarks of the Speaker of The House

Dr. Skinner expressed her Committee's wish to commend Dr. Perry for the clear and precise rules under which the House of Delegates acts and for Dr. Perry's summary given at the beginning of the Meeting.

The remarks of the Speaker presented at the First House of Delegates were filed. (See page 595, First House of Delegates.)

President's Address

Dr. Skinner expressed her Committee's wish to commend Dr. Coleman for his outstanding leadership on behalf of the members of the Association for the past year.

The President's Address presented at the First Meeting of the House of Delegates was filed. (See President's Address, page 585.)

Report of the Committee on Membership Development

The Report of the Committee on Membership Development was adopted as presented.

Committee on Membership Development
Charles K. Donegan, M.D., Chairman

The many and various challenges confronted by the FMA in the past year have emphasized the importance of an effective membership development program within the Association. In the third year of its existence, the Committee on Membership Development met three times to plan membership recruitment programs, as well as membership retention strategies.

At the end of 1984, FMA membership totaled 14,598, an increase of 121 over the comparable figure for 1983. The 14,598 included 12,854 dues paying members, of which 11,726 and 1,128 were in the active and associate member categories, respectively. There were 1,744 physicians in the dues exempt categories.

Florida's AMA member category increased from 10,471 on December 31, 1983 to 10,706 at the end of 1984, which was sufficient for FMA to retain all 11 of its seats in the AMA House of Delegates but 294 short of the number required to gain an additional seat.

Over the past year, the Committee on Membership Development has expanded its work into new areas. A summary of the Committee's more significant activities appears below:

1. **Women Physicians:** Women physicians constitute a significant target for membership development activities. As part of its program for this group, the Committee sponsored a half-day "Leadership Skills Seminar for Women Physicians" during the FMA Leadership Conference in Tampa in February. Approximately 80 women physicians attended. Special membership recruitment letters will be addressed to those non-member women physicians who attended the seminar as well as those who were invited but did not attend.

   The Committee has recommended to the Executive Committee and Board of Governors that a similar program be sponsored at the 1986 FMA Leadership Conference and that it be expanded to a full day.
2. **Membership Retention:** The Board of Governors has directed the Committee on Membership Development to work in the field of membership retention as well as recruitment. The Committee is of the opinion that the retention aspect of membership development can be most effectively addressed at the local level, particularly in the hospital medical staff setting. Accordingly, your Committee has recommended to the FMA Board of Governors that each FMA component medical society be urged to create a membership development committee and that it consider appointing to this committee a representative from each local hospital medical staff, as well as women physicians, resident physicians and medical students, where possible.
3. **Medical Students and Residents:** Upon recommendation of your Committee, the Board of Governors has voted in favor of establishing medical student and resident physician sections within the FMA. Pursuant to this action and a subsequent request from the FMA Committee on Bylaws, the Committee on Membership Development has drafted amendments to the FMA Bylaws that would create a Council on Medical Student Affairs and a Council on Resident Physician Affairs and submitted them to the Bylaws Committee for further consideration. These councils would provide a forum for the expression of resident physician and medical student opinion and also provide a channel for their input into FMA policy-making.
4. **"Invitation to Join" Program:** For the second consecutive year, the Committee on Membership Development is participating in the AMA's "Invitation to Join" membership recruitment program. Under this program, two mailings—one in De-

cember and one in March—were sent to all Florida physicians and resident physicians who, according to AMA records, are not members of either the AMA or the FMA. The first mailing garnered 169 requests for additional information about joining organized medicine.

FMA Speakers' Bureau

The Report of the FMA Speaker's Bureau was adopted as presented.

FMA Speakers' Bureau
Edward R. Annis, M.D., Chairman

Summary of Activities for Year

There are no regularly scheduled or structured meetings for the Speakers' Bureau in that all elected officers, members of the Board of Governors and committee appointees are automatically participants as they reflect official policies and contribute toward the dissemination of information to members of the profession as well as to the public at large. Leading the list of active contributors during the past year has been President Frank Coleman, M.D., with press, radio and television presentations, supplemented by direct meetings with the Governor, leaders of the House and Senate, and responsible business leaders across the state.

Though the problem of professional liability has assumed high priority, the publicly and professionally recognized importance of health cost escalations has received ongoing emphasis. Regulations emanating from Washington and Tallahassee, together with many proposed for future implementation, have demanded ever-increasing activity on the part of all spokespersons for Florida medicine.

Leadership at the county medical society level reflects consistent and continuing expansion of all efforts to educate its members as well as the public on matters vital to preserving access, availability and quality medicine during a time when business and community leaders are concentrating primarily on cost. These actions at the county society level will prove to be most effective, as only an enlightened and motivated public can supply the necessary forces to modify and moderate those determined to limit costs, often at the expense of quality and availability.

Judicial Council

The Reference Committee extended a special commendation to Dr. Joseph H. Davis, Chairman, and to the members of the Judicial Council for their untiring efforts in performing the numerous activities of the Judicial Council during the past year.

The Report of the Judicial Council was adopted as presented.

Judicial Council
Joseph H. Davis, Chairman

The 1985 Annual Report of the Judicial Council will summarize the Council activities since the May 1984 Annual Meeting of the Florida Medical Association. Council duties are defined in Paragraph 8, Section 3 of the Bylaws. The Judicial Council investigates Association activities which pertain to medical ethics, dissension and disputes, complaints by patients against members of the Association, and questions of membership and disciplinary action. The Council reviews and recommends charters for county medical societies. The Council also is the interpretive body for the Association Bylaws. A component county medical society is the basic unit for discipline of its members. Any member subject to such action has a right of appeal to the Judicial Council. The Council may be required to review component county medical societies in respect to their adherence to binding policies adopted by the House of Delegates of the Association.

Since the last Annual Meeting of the Association, the Council has convened on the following occasions: May 2, 1984, September 22, 1984 and March 23, 1985. The current membership of the Council is as follows: Joseph H. Davis, M.D., Chairman, of Miami; O. Frank Agee, M.D., of Gainesville; Robert J. Brennan, M.D., of Ft. Lauderdale; Maurice H. Laszlo, M.D., of North Miami Beach; and Kenneth C. Kiehl, M.D., of Sarasota. The Council has been staffed by Mr. Donald W. Weidner, FMA Associate General Counsel.

The Council's activities are summarized under the following headings:

Grievances

During the last year, the Council has continued to review referred grievances. It is apparent that some procedural improvements are needed.

The procedures for process of these grievances were last considered by the House of Delegates in 1972. Because of the length of time since that consideration, the Council recommended to the Board of Governors, and the Board adopted a motion that the procedures be resubmitted to the House of Delegates for reaffirmation.

In view of the current professional liability crisis, a legislative and news media spotlight has focused upon the way organized medicine fulfills its responsibilities in handling grievances.

The following paragraph is taken from the Judicial Council's Procedures for Investigation and Resolution of Grievances and is even more important today than it was in 1972.

> "It should be kept in mind that for many people who have occasion to file complaints against physicians, the county medical society grievance committee is their only formal contact with organized medicine. With medicine under attack for allegedly not policing its own ranks, it is particularly important that each individual patient be accorded all respect, courtesy and fairness possible by the Grievance Committee and its individual members. Care should be taken that the Grievance Committee's actions do not give rise to charges of 'whitewash', prejudice or inaction."

Often we find that county grievance committees or their staffs, upon receipt of a written complaint, contact only the physician involved. On the basis of the physician's response they then make a decision with no direct contact with the patient. Such a procedure gives rise to a justified impression that the committee did not care about hearing the patient's side of the issue. In every case it is important that the patient be contacted by the county committee and given an opportunity to provide any additional information not contained in his or her complaint. The patient should also be contacted after the physician has responded, should be advised of the physician's response, and should be given an opportunity to comment. The contact with the patient should be by a county committee member. Only in this way can the county grievance committee ensure that most patients will feel that they have been fairly treated.

Within the past year we have seen a significant increase in the number of grievances referred to the Council. At the time of the Annual Meeting last year we had 13 open cases. Today we have 35 open cases and have closed out another 40 cases. Additionally, we received a significant number of cases that were not within

Reference Committee III (Finance and Administration) was chaired by Margaret C.S. Skinner, M.D., Miami. Left to right: T. Byron Thames, M.D., Orlando; Glenn S. Hooper, M.D., Tampa; James T. Cook III, M.D., Panama City; Ms. Linda Flowers, Recorder; Dr. Skinner; Virgil A. Ponzoli Jr., M.D., Naples; John C. Moore, M.D., Lakeland; Robert H. Hux, M.D., Leesburg.

the jurisdiction of the Council either because the physician involved was not an FMA member or a Doctor of Medicine.

The Council also recommended to the Board of Governors that a new bylaw be adopted to provide for automatic suspension or revocation of membership if a member's license to practice medicine is suspended or revoked. When the State Board of Medical Examiners suspends or revokes a physician's license, it is often six months later before the county society or FMA grievance committee can take action against the member. Such a delay is construed by our critics as indifference to our societal obligations.

The Council is in the active process of preparing recommendations in regard to allegations of physician incompetence as it relates to the current malpractice crisis.

Review of County Medical Society Revisions to Charter and Bylaws

During the past year, the Council continued to review bylaw amendments of county medical societies to assure that such amendments are not in conflict with the Bylaws of the Florida Medical Association. County medical societies are urged to submit proposed changes in charters and bylaws to the Judicial Council in a timely manner for such review.

During the past year, the House of Delegates adopted a recommendation of the Judicial Council to create the Bradford County Medical Society and denied creation of a proposed St. Johns County Medical Society .

Florida Medical Association Policy Statement RE: Advertising (1979)

During the past year, the Council amended the endorsed specialty listing section of the Florida Medical Association Policy Statement on Advertising to include the following new approved listings:

Ophthalmology - Pediatric
Hypnosis

Members desirous of a new telephone listing should review the approved specialty code listing found within the American Medical Association Directory of Physicians. The Council considers the following as guidelines when reviewing such requests:

a) the listing serves a public need;
b) it is not redundant with another listing;
c) it is a genuine aspect of the practice of medicine;
d) it has board certified recognition;
e) it describes what the physician does.

The following is the current listing of endorsed specialty headings for yellow page advertising:

1. Aerospace Medicine
2. Allergy & Immunology
3. Allergy & Immunology - Pediatric
4. Anatomic Clinical Pathology
5. Anatomic Pathology
6. Anesthesiology
7. Blood Banking
8. Cardiovascular Disease
9. Child Neurology
10. Child Psychiatry
11. Clinical Pathology
12. Chemical Pathology
13. Colon and Rectal Surgery
14. Dermatology
15. Dermatopathology
16. Diagnostic Radiological Physics
17. Diagnostic Radiology
18. Endocrinology & Metabolism
19. Emergency Medicine
20. Family Practice
21. Forensic Pathology
22. Gastroenterology
23. General Preventive Medicine
24. Genetic Medicine
25. Gynecologic Oncology
26. General Practice
27. Hand Surgery
28. Hematology
29. Hypnosis
30. Infectious Disease
31. Internal Medicine
32. Maternal & Fetal Medicine
33. Medical Microbiology
34. Medical Nuclear Physics

35. Medical Oncology
36. Neonatal-Perinatal Medicine
37. Nephrology
38. Neurological Surgery
39. Neurology
40. Neuropathology
41. Nuclear Medicine
42. Nuclear Radiology
43. Obstetrics & Gynecology
44. Occupational Medicine
45. Ophthalmology
46. Ophthalmology - Pediatric
47. Oral & Maxillofacial Surgery
48. Orthopedic Surgery
49. Otolaryngology - Head & Neck Surgery
50. Pathology
51. Pediatrics
52. Pediatric Cardiology
53. Pediatric Endocrinology
54. Pediatric Hematology - Oncology
55. Pediatric Nephrology
56. Pediatric Surgery
57. Physical Medicine & Rehabilitation
58. Plastic Surgery
59. Psychiatry
60. Psychiatry & Neurology
61. Public Health
62. Pulmonary Disease
63. Radiologic Physics
64. Radioisotopic Pathology
65. Radiology
66. Reproductive Endocrinology
67. Rheumatology
68. Surgery
69. Therapeutic Radiological Physics
70. Therapeutic Radiology
71. Thoracic Surgery
72. Urology
73. Vascular Surgery

Supplemental Report
Judicial Council

The Supplemental Report of the Judicial Council was referred to the Board of Governors and the Board was asked to report to the House with recommendations regarding the items dealing with disciplinary actions and mechanisms for restructuring state and county grievance procedures as outlined in this report.

Supplemental Report
Judicial Council

Joseph H. Davis, M.D., Chairman

It is recognized that incompetency to practice medicine may occur as doctors are human and are subject to the same psychological problems as other people. However, there exists a stringent screening process which is designed to limit to the greatest possible extent incompetency or dishonesty in physicians. This includes: the selection process for schooling; training; certification; licensure; staff privileges; peer review; and, membership in medical societies and oversight by governmental bodies. These processes assure that incompetency and dishonesty should be minimal. Many physicians are, however, partially lost to supervision because they are not members of the Florida Medical Association or their county society.

While organized medicine believes that the number of licensed physicians who are incompetent is very small and that the role of incompetency in the genesis of malpractice suits is also low, we also recognize that organized medicine has an affirmative duty to do everything possible to find and remove from practice or limit the practice of any physician who is incompetent or inadequate. This duty is a legal responsibility, but more important, is part of the Hippocratic oath — we must put the well being of the patients first.

Critics of organized medicine discussing the malpractice crisis make highly publicized claims that:

a. The "bad doctor" is the root cause of malpractice lawsuits.
b. Organized medicine is doing a bad job in protecting the public from such "bad doctors."

An unsatisfactory therapeutic result is definitely not proof that a physician was "bad" or incompetent. However, support for and against the claim that "bad doctors" comprise the substrata for malpractice claims is hampered by lack of factual data.

No system exists to apply epidemiological techniques to litigation threats, institution of proceedings, case settlements and court rulings. No system exists to evaluate the competency of expert medical witnesses for there is no peer review of courtroom medicine. When opposing viewpoints are publicized, the perception is that doctor witnesses may not be trusted.

When litigation is concluded one or both parties are dissatisfied. Such dissatisfaction becomes a further nidus of distrust.

Distorted public perceptions arise from the aforementioned sources. Organized medicine has a most difficult problem regardless of laudable intentions. Therefore, it is incumbent upon organized medicine to constantly strive to exert control of incompetency or dishonesty of doctors while likewise building public confidence that the system is trustworthy and effective.

There exists three systems to control incompetency when it does occur. Each has its strengths and weaknesses. The weakest link in the system is the lack of effective coordination between the three systems which are:

1. The Department of Professional Regulation with its Board of Medical Examiners.
2. The Florida Medical Association with its component county medical societies.
3. The Civil Justice system.

The Department of Professional Regulation with its Board of Medical Examiners has the power to license and to discipline. In recent years it has become much more effective to the point that it ranks highest in the United States in impostion of sanctions against errant physicians. (Feinstein, R.J.: "The Ethics of Professional Regulation," *N. England J.M.*, Vol. 312, No. 12, 801-804, March 21, 1985.)

Currently, the DPR receives relatively few cases, only seven percent (7%), from hospitals or medical societies and the majority of this small percentage comes from hospital referrals.

The DPR operates with paid staff strategically located in the state. It does not utilize committees of the FMA or county societies to screen complaints.

There is a real question whether the Board of Medical Examiners has sufficient investigative staff to properly fill its role. The Board is also hampered by being part of the Department of Professional Regulation and, therefore, being unable to have full control of the priorities of the investigative and legal staff since they work for the Department and not the Board.

The FMA and its component societies have grievance committees. Statewide the Judicial Council acts as the Grievance Committee but refers complaints to the county of origin. The county societies investigate. Complaints may also go directly to the county society, may be heard and never come to the attention of the FMA. If the complainant is not satisfied, there may be an appeal to the Judicial Council.

Although this system has worked reasonably well, there are problem areas. If incompetent doctors are to be controlled by organized medicine then we must review completely the entire system of grievance procedures. Certain preliminary observations are apparent:

1. Neither the FMA nor the component societies have the necessary staff to perform detailed background investigations of each complaint.
2. The voluntary committee system lends itself to needless delay in providing a timely response. This can create the perception that the incompetent physician is being tolerated or, worse yet, approved.
3. There is lack of uniformity in the approach to handling such grievances by the various county committees and county staff personnel.
4. There is no proper data collection system to permit epidemiologicl analyses of the cases throughout the state.
5. There is a lack of consultation between the DPR and the grievance committees quite possibly because the dividing line between a grievance based upon a patient's perception of the physician and a grievance with substantive question of competence is indistinct. In fact, many grievances appear to be fee disputes rather than grievances related to competency or dishonesty. Much can be obviated by improved interpersonal relationships rather than improved technical skills. Obviously, these types of grievances are best handled by organized medicine.

The Civil Justice system, in theory, would be a potential source of information for control of incompetency. However, the truly incompetent physicians are rarely sued while those in high risk specialties are more likely to be sued, not because of incompetence but because of a bad result. Likewise, the entire court system, as now operated, is devoid of good data collection capability for purposes of study of the problems.

How may the Florida Medical Association improve the systems in which incompetent or dishonest physicians come to the attention of the Board and the Association. Improvement may be sought by active participation of the FMA in:

1. Redefinition of systems to control incompetency so that each agency within each system has a clear understanding of its role and its potential for interaction with other agencies both public and private. Although the DPR operates under statutory guidelines and organized medicine operates under charter and bylaws, no formal program exists for supportive interaction. There is a representative from the Board of Medical Examiners on the Board of Governors of the FMA. Physician members of the Board of Medical Examiners belong to the FMA and respective county societies. Most have played an active role in the committee structure of organized medicine. There is need for a more formal interaction with organized medicine offering active support in the promulgation and implementation of policies of the Board of Medical Examiners (DPR). However, a physician member of organized medicine subject to DPR sanctions may look to organized medicine for support. Organized medicine is not a union which should fight for its members right or wrong. The charter of the FMA in Article II states:

   > The general nature of the objects of the corporation is to promote the science and art of medicine and the betterment of public health; to unite the medical profession of Florida into one compact organization and to federate with similar organizations in other states and territories to form the American Medical Association, to extend medical knowledge and to advance medical science; to elevate the standards of medical education; to strive for the enactment, preservation and enforcement of just medical and public health laws; to promote friendly relationships among physicians and to guard and foster their material interests; to enlighten and alert the public; to encourage similar interests and objectives in the corporation's component medical societies, and to carry out these objects of the corporation as a business league not organized for profit, and no part of the net earnings shall insure the benefit of any private member or individual, as an exempt corporation not for profit within section 502(c)(6), 26 U.S.C.A., Internal Revenue Code of 1954.

   The tone of this article in no way indicates that organized medicine should advocate the interests of any physician whose competence or integrity is in question.

   Accordingly, it is recommended that an active ongoing support liaison be established between the Board of Medical Examiners (DPR) and the FMA.

2. When integrity is not a problem, fee disputes, misconceptions between doctors and patients and problems of interpersonal relationships should be clearly separated from the grievance procedure. Mediation committees should be used for these problems. Key to this is a timely and uniform response. Currently, the system(s) are too complex with the FMA involvement being a matter of chance. A new procedure for arbitrating fee disputes should be established under the direction of the Judicial Council. The objective is to create a system which will be uniform in service to the public and which will be a perceived source of service to and for the public.
3. True grievances involving questions of competence or integrity and honesty should be handled by the Board of Medical Examiners (DPR) with tax and license fees supporting adequate staff and personnel to do the job. Organized medicine with its limited dues structure and diverse interests should not attempt to play a strong disciplinary role when the issues are those of license and the privilege of practice. There is no way that organized medicine may fund such an acitivity, and defend its sanctions when challenged, without resort to extensive increase in dues. It might be noted that the Florida Bar spends $2.2 million annually on investigations and discipline. Already, the DPR is spending considerable monies pertaining to physician discipline. It would be wasteful for organized medicine to duplicate those functions which are within the disciplinary purview of the Board of Medical Examiners (DPR). The role of organized medicine should be to forward questions of competence directly to the DPR.
4. The FMA through its legislative activities should support legislation to more clearly define and support improvements in the grievance procedures.
5. The FMA should monitor the civil and criminal court systems and be prepared to route physician questions of competence, both as litigants and expert witnesses, directly to the Board of Medical Examiners (DPR) for full investigation.
6. The FMA should carry out a strong public education program that demonstrates its support for sanctions against the incompetent or dishonest physician. Organized medicine cannot and must not permit itself to be perceived, rightly or wrongly, as indifferent to the "bad doctors" in its midst. The best method is for organized medicine to let it be known that it will encourage investigation by the Board of Medical Examiners (DPR) of any physician when competence or integrity may be in question. By competence, we mean possession of sufficient skills to enable that physician to practice at the level of ability and responsibility in keeping with the accepted standard of care. By integrity, we mean honesty, fairness, morality and decency

so that the patient is being served and managed by the physician in the same manner as the physician would want himself or a loved one to be served and dealt with if they were in the patient's situation.

Florida Medical Foundation

The Report of the Florida Medical Foundation, with the exception of the item referred to another Reference Committee, was adopted.

Florida Medical Foundation
Luis M. Perez, M.D., President

The Florida Medical Foundation Board of Directors has continued to hold their meetings in conjunction with the meetings of the Florida Medical Association Board of Governors. The Florida Medical Foundation Professional Review Organization of Florida, Inc., submitted a proposal to the Health Care Financing Administration to become the designated statewide PRO for the state of Florida. The major activities of the Foundation are summarized as follows:

1. **Peer Medical Utilization Review (PMUR):** The PMUR Committee was very active and met six times this Association Year. Over 168 physicians were reviewed including 35 appeals. The Committee has reviewed Medicare, Medicaid and Workers' Compensation cases. A moratorium implemented by the HCFA effective March 1, 1985 has put PMUR review for Medicare cases on hold until August or September, at which time it is expected that Medicare review will resume. This moratorium has been initiated due to lack of funding. (Referred to R.C. V)
2. **Committee on Impaired Physicians:** Included in the Delegates' Handbook is a report on the activities of the Committee on Impaired Physicians. This Committee continues to provide a tremendous service with outstanding results.
3. **Committee on Continuing Medical Education:** The Committee, as an organization accredited by the Accreditation Council for Continuing Medical Education (ACCME) and the Florida Medical Association, continues to make major contributions to continuing medical education in Florida. In 1984, the Committee reviewed and approved 65 applications from specialty groups, hospitals and other CME providers for a total of 710 hours of American Medical Association Category I credit. Additionally, members of the Committee have actively served as members of site survey teams for the accreditation of hospital-based programs of continuing medical education. The activities of the Committee continue to assure physicians of Florida that educational programs offering AMA Category I credit are of the highest quality. (Referred to R.C. I)
4. **Medical Student Loans:** The Foundation's Medical Student Loan Program is still under a moratorium, which has been in effect since 1977. The nine loans for which the Foundation repaid the bank in 1981 are slowly being repaid to the Foundation. The outstanding balance on these loans is currently $21,204.78. Payments are being made regularly on four of the loans; three have been turned over for collection through legal channels; and two are pending litigation.

   In June, 1984, the Foundation was asked by the Florida National Bank Trustee for the Guaranteed Medical Student Loan Program, to repay another $31,645 in delinquent loans of eight recipients. Concentrated collection efforts have been directed toward these by the Foundation, and they are now in varying stages of repayment. The outstanding balance of these now stands at $27,555.79. The recipients are being charged interest on their respective unpaid balances at 10% per annum until the balances are repaid.

   With the continuing efforts and attention being given to the collection of these loans, we are optimistic that the outstanding balances will be reduced considerably during the next year.
5. **Florida Medical Association Auxiliary:** The Foundation is indebted to the Florida Medical Association Auxiliary for its loyalty in supporting the Foundations' programs.

   In addition to its representative on the Committee on Impaired Physicians, the Auxiliary raised $5,000 in funds which it donated to the Foundation, earmarked for use in the Impaired Physicians Program. The Auxiliary has also designated the proceeds from the second printing of its cookbook, entitled "RX for Fine Dining", to be donated to the Foundation for the Impaired Physicians Program.
6. **Professional Review Organization of Florida, Inc.:** The Professional Review Organization of Florida, Inc., (PROF) submitted a detailed two volume proposal to be designated the statewide PRO to the Health Care Financing Administration on April 27, 1984. Subsequently, the PROF submitted a revised proposal on June 15, 1984. On June 26, 1984 the PROF entered into negotiations with HCFA officials and as a result was asked to submit a "Best and Final" offer on July 5, 1984. The contract was awarded on July 13, 1984 to the Professional Foundation for Health Care (the existing PSRO in Tampa, Florida). The PROF, Inc., requested HCFA to provide detailed information on the reasons why the contract was awarded to the Professional Foundation for Health Care, Inc., and as a result participated in a debriefing session in Baltimore, Maryland with the HCFA negotiating team on July 25, 1984. As a result of the award of the contract, the FMA Professional Review Organization of Florida, Inc., filed a protest with the United States General Accounting Office (GAO). In addition, the PROF has filed a lawsuit under the Freedom of Information Act because of HCFA's unwillingness to supply the PROF with pertinent information regarding the Professional Foundation for Health Care's proposal. A hearing was held with the GAO on October 25, 1984. No decision to date on the protest or lawsuit has been rendered. (Referred to R.C. V)

Margaret C.S. Skinner, M.D., Chairman, Reference Committee III, addressed the House of Delegates.

Supplemental Report
Florida Medical Foundation

The Supplemental Report of the Florida Medical Foundation was adopted as presented.

This Supplemental Report updates the report of the Florida Medical Foundation in order to report on recent activities that have occurred pertaining to the Professional Review Organization of Florida, Inc., the FMA's entity, that submitted a PRO proposal to the Health Care Financing Administration (HCFA).

The following is a chronological order of events that have taken place since the Peer Review Organization of Florida, Inc. submitted a proposal to the Health Care Financing Administration to be designated the statewide PRO.

On April 27, 1984, the Professional Foundation of Florida, Inc., submitted their two-volume proposal to be designated as the statewide PRO. This proposal included both a business and technical proposal.

During the week of April 14 to April 18, 1984, the PROF's business proposal was intensely reviewed by Arthur, Anderson and Company, CPA firm, who gave the business proposal a favorable audit.

On June 8, 1984, the PROF was requested by HCFA to provide additional supplemental materials and to elaborate on several questions that were asked. A detailed 600-page Supplemental Report was prepared in less than a week and submitted to HCFA on June 15, 1984.

On June 25, 1984, the PROF entered into negotiations with the Health Care Financing Administration to be designated the statewide PRO and at that time were requested to submit a best and final offer on July 5, 1984.

On July 13, 1984, the Health Care Financing Administration awarded the statewide PRO contract to the Professional Foundation for Healthcare, Inc. (Tampa PSRO).

On July 18, 1984, after assistance from the Florida House and Senate Delegation, the Florida Medical Foundation's Peer Review Organization of Florida, Inc., conducted a conference call with HCFA officials to determine the reasons why the contract was not awarded to the Professional Review Organization of Florida, Inc.

On July 19, 1985, the Professional Review Organization of Florida, Inc., filed a protest with the General Accounting Office of the United States Government. This protest was based on the fact that:

1. The contracting authority omitted in the request for proposal specific sections, essential terms, thereby putting the Professional Review Organization of Florida, Inc. at a distinct disadvantage in a competitive bid;
2. The criteria for evaluating proposals was not set forth in a clear and understandable manner;
3. The contracting authority failed, during the negotiations, to ask appropriate questions and to impart intellegible information to the Professional Review Organization of Florida, Inc., which put the Professional Review Organization of Florida, Inc. at a distinct disadvantage;
4. The contracting authority supplied erroneous information;
5. The contracting authority failed to recognize the Professional Review Organization of Florida, Inc.'s vast amount of peer review experience accumulated over the last 10 years; and
6. The Professional Review Organization of Florida, Inc. also based their protest on the fact that significant criteria was utilized to determine the awarding of the contract which was not included in the request for proposal.

On July 23, 1984, the Professional Review Organization of Florida, Inc., requested under the Freedom of Information Act information pertaining to the awarding of the contract including details as to what areas the competitors had significant gains in the awarding of points as well as any other information used to make this determination.

On July 25, 1984, the Professional Review Organization of Florida, Inc., met with HCFA officials in Baltimore for a debriefing session. At that time the PROF was advised of the reasons why they were not awarded the contract. Based only on the PROF's proposal, no information was given about the proposal that was awarded.

On August 20, 1984, the Professional Review Organization of Florida, Inc. filed suit against the Department of Health and Human Services for failure to provide information as requested under the Freedom of Information Act in a timely manner.

On October 25, 1984, the Professional Review Organization of Florida, Inc., participated in a General Accounting Office hearing held in Washington D.C. As a result of this hearing, the Professional Review Organization of Florida, Inc., submitted an amended protest based on information presented by Mr. Salazar of the Florida Peer Review Organization, Inc., who specifically stated that he was told during the negotiation session that their organization should attempt to achieve a 10% impact on state Medicare admissions as part of its best and final offer. The Peer Review Organization of Florida, Inc., did not receive such guidance and, in fact, were told to achieve a 4.5% to 5% deduction in total Medicare admissions within the state.

On April 5, 1985, the Professional Review Organization of Florida, Inc., was notified of the decision of the hearing with the General Accounting Office of the United States Government. The protest of the Professional Review Organization of Florida, Inc., was denied by the GAO.

The Professional Review Organization of Florida, Inc., and the FMA Committee on PRO is currently reviewing the results of the protest and the freedom of information act lawsuit, recommendations of the law firm of Williams and Connolly, and will make recommendations to the Board of Governors at the June Meeting.

Florida Medical Foundation
Committee on Impaired Physicians

The Report of the Florida Medical Foundation Committee on Impaired Physicians was adopted as presented.

Florida Medical Foundation
Committee on Impaired Physicians
Guy T. Selander, M.D.

A year-long search for a full-time medical director for the FMA-FMF Impaired Physicians Program has been successful, making 1984-85 another landmark year for the Committee on Impaired Physicians.

In February, the Committee on Impaired Physicians and the FMA Executive Committee agreed to offer the position to Roger A. Goetz, M.D., a Milwaukee native who most recently was located at Columbia, S.C. Dr. Goetz, an anesthesiologist by training, has been involved in the treatment of impaired physicians for several years. He is a member of the Board of Directors of the American College of Addictionology.

Dr. Goetz assumed the position in February, succeeding Dolores A. Morgan, M.D., of Miami, who has served ably as medical director of the IPP on a part-time basis since the inception of the program in the Fall of 1980. Initially, Dr. Goetz will maintain his office in Jacksonville, which is subject to change later.

Dr. Goetz's duties will include liaison with the Florida State Board of Medical Examiners and organizations of health care professionals that maintain impairment programs; liaison with

county medical society impaired physicians committees; formation of intervention teams; refinement of the treatment facility accreditation process; arrangement of educational programs; speaking engagements before lay and professional groups; and coordination of after care monitoring.

Following is a summary of other activities of the Committee on Impaired Physicians over the past year:

1. **Reporting to DPR:** After months of negotiations, the Committee reached agreement with the Florida Department of Professional Regulation regarding the reporting of cases as required by S. 458.3315(5) (a), F.S. Under the agreement, treatment program directors are to report each physician admitted for treatment to the Board of Medical Examiners' impaired professionals program consultant. Physicians will not be identified by name but by an "addiction treatment number". In the event a physician patient drops out of treatment or is considered a danger to patients, he or she shall be reported to the consultant by the treating physician. If, after consultation the consultant determines that a complaint should be filed with DPR, the treating physician or medical director will furnish the name to the consultant.
2. **Treatment Facilities:** The Committee approved two additional treatment facilities during the past year. These are Mt. Sinai Medical Center of Miami Beach and Bowling Green Inn. Several other facilities were reviewed but not approved because they did not meet one or more of the Committee's criteria.
3. **Section on Chemical Dependency:** For the fifth consecutive year, the Committee is sponsoring a Section on Chemical Dependency at the FMA Annual Meeting. "Substance Abuse: Consequences and Implications" will be the theme of this year's program, which is scheduled for 1:00 p.m. to 4:00 p.m. on Thursday, May 2, at the Diplomat Hotel in Hollywood.
4. **Gift to AMA:** The Committee made a gift to the American Medical Association of a framed Lee Adams *Caduceus* print. The art piece bears the inscription "Presented to the American Medical Association by the Florida Medical Association Committee on Impaired Physicians, June 1984", and it will be on permanent display in the AMA Chicago headquarters.
5. **EMTS and Paramedics:** The Committee provided without charge consultative service to the Florida Office of Emergency Medical Services regarding the development of a program for impaired emergency medical technicians and paramedics.
6. **Lectures and Speeches:** Members of the Committee continued to be available to address various audiences on the matter of impairment and related subjects. Some of the notable appearances this year included the medical director's talk on dealing with stress and avoiding burnout at the FMA's "Leadership Skills Seminar for Women Physicians" on February 1; and the Chairman's presentation at the first Statewide Conference on Prescription Drug Abuse in Tampa, October, 1984.

Florida Medical Political Action Committee (FLAMPAC)

The Report of the Florida Medical Political Action Committee was adopted as presented.

Florida Medical Political Action Committee (FLAMPAC)

Robert E. Windom, M.D., President

Political Action Program - 1984

1984 was an extremely successful year for the Florida Medical Political Action Committee. The election results were much improved over the 1982 election. An increased number of physicians and their spouses participated as volunteers in individual legislative and congressional races, and the financial contributions to FLAMPAC far exceeded any previous years' total.

These successes have created a significant reserve account that can be carried forward as a base for increased volunteer recruitment, training and development of additional resources, e.g., polling, independent expenditures, etc., that can be brought to bear during the 1986 election.

The continuing organizational and personal support provided to FLAMPAC by the members of the FMA Board of Governors and the FMA Executive Director has made these achievements possible and will ensure the continued growth and maturing of medicine's statewide political action arm.

The General Election was a most successful one for FLAMPAC. We were on the winning side on all 11 congressional candidates supported, won five of six for Florida Senate and won 41 of 47 House of Representatives' races. This is an overall winning percentage of 87.5%.

Of the Florida Senate and House races in the General and Primary Elections, 32 of 35 "Friends of Medicine" were re-elected. In the General Election, we were successful in 26 of 29 races that the Board determined to be of critical importance. Three physicians - Senator William G. Myers, M.D. (R), Representative Bernard Kimmel, M.D. (R) and Representative David Thomas, M.D. (R) and one physician's spouse, Representative Betty Metcalf (D) were elected. (Dr. Thomas is the new addition to the "medical family" members in the Legislature.)

There was no change resulting in the elections among the House and Senate Democratic leadership, but it appears that our base of support on the floor of the House has been strengthened.

Membership

Final FLAMPAC membership contributions in 1984 exceeded the quota established by more than $48,000. This occurred in spite of a lower than projected membership total. A significant achievement is the record number of 4,697 individuals who joined FLAMPAC as Sustaining Members.

This increased financial support by physicians and their spouses enabled FLAMPAC to play a significant financial role in congressional and legislative races. In addition, the individual monetary and voluntary contributions at the local level provided the margin of victory in several key legislative races.

For the first time AMPAC has recognized state medical associations in a new membership activity that ranks states based upon the AMPAC year-to-date membership as compared to the AMA's membership prior year figures for the particular state. For 1984, Florida ranked number one among all state medical association political action committees with a lead of 9 percentage points above second place Texas Medical Political Action Committee.

FLAMPAC Officers and Board

The FLAMPAC Board of Directors elected the following persons as officers for FLAMPAC during 1985:

Robert E. Windom, M.D., President
James G. White, M.D., Vice President
Carlos G. Llanes, M.D., Secretary
Louis C. Murray, M.D., Treasurer
Donald C. Jones, Assistant Treasurer

The FMA Board of Governors as provided in the FLAMPAC Bylaws has appointed an outstanding list of physicians and their spouses to serve as the FLAMPAC Board of Directors during 1985. Persons appointed to the FLAMPAC Board of Directors for 1985 are:

Florida Congressional Districts:
William W. Thompson, M.D. (1st)
Terence P. McCoy, M.D. (2nd)
Mrs. James H. Corwin (3rd)
James G. White, M.D. (4th)
Louis C. Murray, M.D. (5th)
Frank R. Wilkerson Jr., M.D. (6th)
Frank C. Coleman, M.D. (7th)
James L. West, M.D. (8th)
Donald G. Nikolaus, M.D. (9th)
John W. Glotfelty, M.D. (10th)
Brian P. Gibbons, M.D. (11th)
Paul W. Taylor, M.D. (12th)
Robert E. Windom, M.D. (13th)
Dick L. Van Eldik, M.D. (14th)
T. W. Hahn, M.D. (15th)
Stanley I. Margulies, M.D. (16th)
James W. Bridges, M.D. (17th)
Margaret Skinner, M.D. (18th)
Warren Lindau, M.D. (19th)

Members of FMA Auxiliary:
Mrs. B. David Epstein
Mrs. Arthur L. Eberly
Mrs. Donald G. Nikolaus

Liaison Representatives from FMA Board of Governors:
Luis M. Perez, M.D.
Kay K. Hanley , M.D.

Members of FMA Council on Legislation:
Thomas M. Daniel, M.D.
Michael J. Pickering, M.D.

Members from the State At-Large:
H. Quillian Jones Jr., M.D.
R. Benjamin Moore, M.D.
Carlos G. Llanes, M.D.
Juan Wester, M.D.
Alvin E. Smith, M.D.
Richard S. Hodes, M.D.

President-Elect of FMA Auxiliary:
Mrs. Milton Tignor (Ex-officio)

Florida Physicians Association

The Reference Committee heard extensive testimony regarding the history of the Florida Physicians Association and of the potential areas in which the Association has been and can be of benefit to the membership.

The motion of the Reference Committee recommended that the Report of the Florida Physicians Association be referred to the Board of Governors and that the Board make a diligent effort to explore a broader scope of activities for the Florida Physicians Association that will effectively address those medical economics' issues affecting physicians deemed appropriate, and which are outside the purview of the FMA and its component county medical societies carried.

Florida Physicians Association

David T. Overbey, M.D., President

The Florida Physicians Association is a non-profit corporation founded in December 1972 to protect the private practice of medicine by becoming involved in activities that the Florida Medical Association cannot enter into because of Charter restrictions and legal ramifications.

As of the date of this report, the Florida Physicians Association has 3,078 members and is expected to grow even larger by the Annual Meeting.

During the past year, the Florida Physicians Association has been requested to provide financial help in countering alleged false advertising and deceptive practices of Health Maintenance Organizations. Action on this issue has been deferred until the Annual Meeting of the Florida Physicians Association.

The Florida Physicians Association was contacted to help provide financial aid for the Reason '84 constitutional amendment campaign. The FPA Board of Directors was polled by phone and with majority consent a substantial financial donation was made to the Campaign.

The Florida Physicians Association meets regularly at the time of the FMA Annual Meeting and reports to the FMA Board of Governors.

It is our hope that this organization will be able to preserve, protect and defend the private practice of medicine and the people of Florida from charlatans and purveyors of questionable business practices more interested in their profit rather than the welfare of the people and the individual medical practitioner.

Florida AMA Delegation

The Report of the Florida AMA Delegates was adopted as presented.

Florida AMA Delegation

Charles K. Donegan, M.D., Chairman

It has been a pleasure for me to serve as Chairman of your Florida AMA Delegation during the past year, ably assisted by our Vice Chairman, Joseph C. Von Thron, M.D.

The effectiveness and influence of our delegation at the national level is due to the time and effort given freely by your delegates and alternate delegates. A great deal of appreciation goes to:

T. Byron Thames, M.D., Delegate
Samuel M. Day, M.D., Delegate
Burns A. Dobbins Jr., M.D., Delegate
Richard G. Connar, M.D., Delegate
Charles J. Kahn, M.D., Delegate
Joseph C. Von Thron, M.D., Delegate
Louis C. Murray, M.D., Delegate
Robert E. Windom, M.D., Delegate
Luis M. Perez, M.D., Delegate
Sanford A. Mullen, M.D., Delegate
Vincent P. Corso, M.D., Alternate
James B. Perry, M.D., Alternate
Frank C. Coleman, M.D., Alternate
Eugene G. Peek Jr., M.D., Alternate
Vernon B. Astler, M.D., Alternate
O. William Davenport, M.D., Alternate
James W. Walker, M.D., Alternate
Joseph T. Ostroski, M.D., Alternate
Arthur L. Eberly Jr., M.D., Alternate
Dick L. Van Eldik, M.D., Alternate
William B. Deal, M.D., Alternate

We are pleased to announce that our caucuses had present the delegates from Puerto Rico, Fernando J. Cabrera, M.D., and Emilio Arce, M.D.; the delegates from the Virgin Islands, Felix Pitterson, M.D., and Howard E. Hill, M.D.; and the AMA Delegate from Guam, Leon L. Concepcion, M.D.

In addition to our delegation, we were joined by many county medical society representatives and representatives from Florida to the Hospital Medical Staff Section.

The AMA was faced with another year filled with a broad range of issues. The following is a summary of major actions taken by the House and of the activities of our Florida delegation during the Annual Meeting, June 17-21 and the Interim Meeting, December 2-5. The activities of your delegates have been reported to the FMA Board of Governors and the FMA membership through various Association publications.

1. **Southeastern Delegation:** Your delegation was again active in the Southeastern Delegation which is composed of the following states:

Alabama	Maryland
Delaware	Mississippi
District of Columbia	North Carolina
Florida	South Carolina
Georgia	Virginia
Louisiana	

Activities included a breakfast caucus on Sunday morning, at which time major items of business to be addressed by the House were discussed, and receptions were hosted at noon on Sunday, and on Monday and Tuesday evenings.

2. **Resolution:** The Florida Delegation introduced a resolution at the AMA Interim Meeting. Resolution 43, Peer Review Organizations, was considered along with other state resolutions regarding various aspects of the Health Care Financing Administration's (HCFA) implementation of Peer Review Organizations.

RESOLVED, that the American Medical Association convey to the Secretary of the Department of Health and Human Services that the Peer Review Organization Program, created as part of the Tax Equity and Responsibility Act of 1982 (PL 97-248) and as implemented through the Request for Proposal, has made cost saving quotas more important than insuring the quality of medical care; that the admission and quality objectives of individual bidders were analyzed on a subjective basis; that the Health Care Financing Administration (HCFA) failed to pursue serious flaws in several "winning" proposals which suggests that the personnel conducting the evaluations were incompetent in performing their jobs; that the legislative intent in creating PROs has not been adhered to; that physician-sponsored organizations have been purposely excluded; and that the basis on which contracts awarded to date will result in the loss of millions of taxpayers' dollars; and be it further

RESOLVED, that the AMA conduct an immediate and comprehensive review of the Tax Equity and Responsibility Act of 1982 (PL 97-248) and the manner in which it is being applied by HCFA of the Department of Health and Human Services and recommend any appropriate legal or legislative actions to remedy the deficiencies cited herein.

The following is a summary of other major actions taken by the AMA House of Delegates:

1. **Future Directions and Resource Needs:** The House approved several recommendations of the Board of Trustees contained in a major report regarding AMA finances and membership.

— Of foremost interest to AMA members is that AMA dues will be maintained at current levels in 1985. The Reference Committee cautioned the House, however, that future AMA dues may have to be increased by $30 in 1986 and an additional $30 in 1987 in order to avoid major reductions in AMA programs and activities in those years.
— State medical associations will be allocated one extra delegate when 75 percent or more of the state society's members are also AMA members. Unified states (Illinois and Oklahoma) will be granted two additional delegates.
— The dues exemption policy was revised so that this membership category is limited to members who are at least 70 years of age and fully retired or suffering financial hardship and/or disability.
— Members who are at least 70 years of age and working not more than 20 hours per week pay one-half of regular dues.
— Members who previously qualified for dues-exemption under criteria other than financial hardship would continue to be eligible under the grandfather clause.
— The Judicial Council was expanded from five to seven members to aid the Council in its effective consideration of a growing number of ethical concerns.

2. **Diagnosis-Related Groups (DRGs):** Easily the dominant issue at the Annual Meeting was DRGs and their effect on the quality, cost, and availability of care. The House directed the Board to place a high priority on monitoring the system and report back at the 1984 Interim Meeting. In other related actions, the House voted to:

— Continue the AMA's strong and concentrated efforts to seek elimination of the DRG attestation statement that requires physicians to certify primary and secondary diagnosis and procedures.
— Seek legislative and regulatory changes to ensure that differences in DRG-based payments to different categories of hospitals (rural and urban) are based on true differences in the costs of providing services by those hospitals rather than on arbitrary geographic criteria.
— Oppose the mandated algorithmic or cookbook/decision tree method of establishing a treatment regimen as cost effective under the Medicare payment system.
— Oppose the expansion of DRGs to physicians.
— Seek changes in the DRG system to provide adequate reimbursement for events arising during hospitalization that significantly add to a patient's requirements for care.

3. **Health Policy Agenda:** A special reference committee was appointed to consider the 159 principles developed by the Health Policy Agenda for the American People. These principles are broad value statements about what should exist in the health policy arena. Instead of adopting the principles as AMA policy, the House voted to endorse them as working principles to help guide AMA representatives to HPA Work Groups and Advisory Committees throughout the remainder of the project, scheduled for completion in 1986. In its next phase, the HPA will translate the principles into policy recommendations and action plans.

4. **Automobile Safety:** The House considered several resolutions related to the use of air bags and seat belts. The House supported:

— Mandatory installation of air bags in domestic and foreign cars.
— Legislation promoting the availability of seat belts in all motor vehicles, including buses and taxis, used to carry passengers.

— Mandatory seat belt use laws.
— Mandatory child passenger restraint laws.

5. **Tobacco and Health:** Taking an aggressive anti-smoking stance, the House approved several policies to position the Association in the forefront of anti-smoking groups. The House voted to:
   — Urge Congress to strengthen warnings on cigarette packages to say that smoking causes cancer of the mouth, larynx, and lung; is a major cause of heart disease and emphysema; is addictive; and may result in death.
   — Study the safety and efficacy of nicotine chewing gum as an aid to smoking cessation.
   — Ask the Surgeon General to place health hazard warnings on all snuff and chewing tobacco packages.
   — Encourage physicians to schedule extra time to explain the health hazards of smoking to their patients.
   — Urge hospitals, offices, and all other medical care facilities to declare themselves off limits to smoking.
   — Work to protect the health of non-smokers on airplanes.
6. **Hospital Medical Staff Issues:** The Hospital Medical Staff Section met for two days prior to the opening of the AMA House. Over 700 representatives were registered from virtually every state. They considered about 60 resolutions and submitted 18 resolutions for consideration by the AMA House. Enthusiasm among HMSS representatives remains high and participation in this policy-making process is expected to increase. The goal is to have every hospital send a representative to further enhance communication between the AMA and local hospital medical staffs. The AMA House approved a number of resolutions related to the organization and operation of the medical staff. The House:
   — Supported the medical staff's authority to approve or disapprove all amendments to medical staff bylaws.
   — Supported the idea that hospital governing boards cannot unilaterally change medical staff bylaws.
   — Asked the AMA to prepare and distribute a document on the legal status of medical staffs.
   — Encouraged hospitals and medical staffs to make all medical staff rules available to physicians.
   — Directed the AMA to oppose any regulation that would mandate voting privileges for non-physician members of the medical staff.
   — Recommended that medical staffs develop bylaw provisions that affirm the binding effect of medical staff bylaws on the hospital governing board and the medical staff.
7. **Professional Liability:** On the last day of the meeting, the Board of Trustees submitted a report informing the House that a special task force would be established to study professional liability. The task force is charged with coordinating current AMA activities and focusing them on professional liability insurance. AMA Executive Vice President, James H. Sammons, M.D., will chair the task force. Other members include AMA General Counsel, the Assistant Executive Vice President, and two Deputy Executive Vice Presidents. The Board will submit a report at the 1984 Interim Meeting.
8. **Cognitive Services Reimbursement:** The House considered five resolutions pertaining to reimbursement for cognitive services. The House approved a substitute resolution that asked the AMA to:
   — Support the concept that third party payors should provide more equitable reimbursement for physicians' services which are solely cognitive in comparison with their procedural services.
   — Take appropriate action to promote more equitable reimbursement for solely cognitive services with third party payors, business groups, and other professional associations.
9. **Illegal Medical Degrees:** The House voted to continue to assist appropriate private and governmental agencies in identification of persons possessing illegally obtained medical degrees.
10. **Maternity Leave for Residents:** The House adopted a report that recommends that residency program directors develop a written policy on maternity leave for residents.
11. **Protective Headgear for Horseback Riders:** The House approved the following guidelines regarding participation in horseback riding activities:
   — Educational programs be given to parents, riding instructors, show organizers, and managers outlining the risks in horseback riding and methods to minimize them.
   — Satisfactory, protective headgear be selected for each type of riding activity and when riding or preparing to ride.
   — Individuals riding horses be encouraged to wear protective headgear.
12. **IRS Physician Impersonation:** The House received a late resolution pertaining to a recently announced IRS campaign to have IRS agents impersonate physicians and other professionals. The House asked the AMA to monitor the situation and report back at the 1984 Interim meeting.
13. **Boxing:** The House considered four resolutions calling for opposition to the sport of boxing. The House combined these resolutions into a clear statement that places the Association in the forefront of organizations calling for a total ban on boxing. This issue received much national media attention. The House called on the AMA to:
   — Encourage the elimination of both amateur and professional boxing, a sport in which the primary objective is to inflict injury.
   — Communicate its opposition to boxing to appropriate regulating bodies.
   — Assist state medical societies to work with their state legislature to enact laws to eliminate boxing in their jurisdictions.
   — Educate the American public, especially children and young adults, about the dangerous effects of boxing on the health of participants.
14. **Chelation Therapy:** Another timely issue involves use of chelation therapy. The House spent much time in developing a policy statement on this controversial treatment. The policy reads as follows:

   RESOLVED, AMA reports show that there is no scientific documentation that the use of chelation therapy is effective in the treatment of cardiovascular disease, atherosclerosis, rheumatoid arthritis, and cancer; and be it further

   RESOLVED, That if chelation therapy is to be considered a useful medical treatment for anything other than heavy metal poisoning, hypercalcemia, or digitalis toxicity, it is the responsibility of its proponents to (a) conduct properly controlled scientific studies, (b) adhere to FDA guidelines for the investigation of drugs, and (c) disseminate results of scientific studies in the usually accepted channels.

15. **Professional Liability:** The House approved two progress reports on the Association's activities in professional liability. One report presents the results of the AMA Committee on Professional Liability's study of costs, tort reform, and other aspects of this complex problem. The Committee was established in 1982. Another report on the activities of the Special Task Force on Professional Liability was established by the Executive Vice President last June. The Task Force's purpose

is to coordinate, prioritize, and expand the AMA's activities in the professional liability area.

16. **Public Image of Physicians:** Concern for negative public opinion toward physicians was uppermost in the minds of the delegates. The House approved a comprehensive and thoughtful report on the Association's current activities and plans for improving the public image of physicians. The report noted:

— "Organizational efforts to improve the public image of physicians are inherently limited and can never replace the actions of individual physicians committing themselves to spending more time with patients, giving them better instructions, and discussing their fees."
— Public perceptions take many years to form, and since the problem has been developing for a long time, it will not be solved quickly.

* Public perceptions of physicians are often inconsistent, and at times contradictory depending upon the background and experience of the individual.
* Public expectations, another image issue, are often unattainable.

In addition to the above report, the House adopted a substitute resolution formulated by the Reference Committee. It called upon the AMA to:

— Strengthen its efforts to increase the public's awareness that physicians are patient advocates.
— Develop and implement an immediate program to focus on increasing the public's understanding of key changes that are occurring in the health care delivery and the impact that such changes will have on health care quality and access.
— Plan a long-range national public education campaign utilizing consultants with established reputations.
— Provide assistance and encouragement to state and county associations to develop and implement similar public awareness programs and monitor and evaluate such programs for their effectiveness.

17. **Benefits of Unified Membership:** The House approved several recommendations of the Board of Trustees providing additional benefits to members in unified states. The new benefits are designed to encourage and retain unification. Currently, only Oklahoma and Illinois are unified states. The new benefits include:

— Services of an AMA ombudsman within the organizational structure.
— Ten percent dues discount for members excluding students and residents.
— Staff services for specialty projects.
— Specialty briefings for officers of unified societies.
— A specialty Advisory Committee to meet regularly with the Executive Committee of the Board of Trustees and the EVP.
— A higher reimbursement rate to constituent societies for dues collection.

Also, the House asked the Board of Trustees to study alternative mechanisms to provide membership incentives for all state, county, and specialty societies who have successful recruitment programs.

18. **AMA Budget:** The House approved a fiscal year 1985 budget based on operative revenues of $125,430,000 and operating expenses of $124,580,000 with an anticipated favorable balance of $1,850,000. Incorporating an AMACO gain of $670,000 and a provision for income taxes of $930,000, the anticipated revenue in excess of expense is $1,590,000.

There is no dues increase for 1985.

Before the House considered the budget, the Reference Committee cautioned the delegates that the $1.6 million is a narrow margin and about 1% of the total budget. It imposes severe limitations on the growth of activities that can occur in the year ahead without additional revenues or displacement of existing activities.

19. **Peer Review Organizations:** The House considered six resolutions, including Resolution No. 43 presented by the Florida Medical Association, regarding various aspects of HCFA's implementation of PRO. There were several speakers who emphasized the difficulties of negotiating realistic performance objectives in the PRO contracts. Also, the delegates complained about the inappropriate emphasis on cost containment rather than the quality of services provided. The House directed the AMA to:

— Continue its support for professionally directed programs of medical peer review which places the emphasis on quality rather than cost.
— Actively oppose HCFA's use of arbitrary admission and quality objectives in the activities of PRO.
— Implement a PRO monitoring system to obtain documentation necessary to redress PRO implementation problems through legislative and regulatory means.
— Urge the Federation to collect and provide information to the Association.
— Actively seek legislation to correct demonstrated inequities in the implementation of the PRO program.

20. **Opinions of the Judicial Council:** The House discussed and approved a number of ethical issues in considering four important reports from the Judicial Council.

— "Physician-Patient Relationships: Respect for Law and Human Rights" which prohibits illegal discrimination in the physician-patient relationship.
— "Terminal Illness - Patients' Preferences" which relates to "living wills" authorizing withdrawal from life support systems when the patient is irreversibly terminally ill.
— "New Medical Procedures" which states that physicians have an obligation to share their knowledge and skills, and to report the results of their research.
— "Surrogate Parenting" which urges couples with infertility problems to investigate the alternatives available to them, including adoption. The Judicial Council believes that surrogate motherhood presents many ethical, legal, psychological, societal, and financial concerns and does not represent a satisfactory reproductive alternative for people who wish to become parents.
— "Hospital-Physician Risk-Sharing Arrangements" under DRGs which advises that physicians may not derive a profit, nor be financially penalized, nor risk loss of hospital privileges under profit or loss sharing agreements.

21. **Hospital Medical Staff Section:** With increasing maturity and sophistication, the Hospital Medical Staff Section continues to grow in influence within the House of Delegates. The HMSS at its fourth assembly meeting grappled with the problems of physician-hospital relations. Over 400 representatives attended and submitted 14 resolutions to the AMA House. Virtually every state and territory was represented and the delegates learned that 31 state medical associations have created similar sections to deal with these issues at the local level.

22. **Medical Acts by Unlicensed Individuals:** The encroachment of non-physicians into the practice of medicine stimulated four resolutions and much debate in the House. Although

AMA policy on the issue was reaffirmed, the delegates called for more aggressive actions, including:

— Monitoring legislative and regulatory activities.
— Disseminating information concerning such activity as expeditiously as possible.
— Developing a pro-active program to provide AMA legislative and staff support to assist state medical and specialty societies in their efforts to oppose enactment of new legislation which authorizes independent practice of medicine by individuals who are not licensed to practice medicine and surgery in all its branches.

23. **Scientific Reports:** The House agreed to permit the publication of reports from the Council on Scientific Affairs without the approval of the House. This new practice will allow earlier dissemination of scientific information. At this meeting the Council submitted a number of scientific reports. Topics included:

— The Health Effects of Agent Orange.
— Diagnostic and Treatment Guidelines for Child Abuse and Neglect.
— Effects of Toxic Chemicals on the Reproductive Cycle.
— Nicotine Chewing Gum for Cessation of Smoking.
— Guidelines for Reporting Estimate of Probability of Paternity.

24. **AMPAC Year-End Report:** The American Political Action Committee (AMPAC) enjoyed a record-breaking year in 1984, AMPAC Chairman Fred J. Rainey, M.D., told the AMA House of Delegates. During the 1983-84 election cycle, Dr. Rainey said, AMPAC participated in 578 campaigns, with a 90% success rate. He noted that this included support for 233 Democrats and 345 Republicans, providing the bipartisan nature of the organization and demonstrating that "party labels have no place in our decisions." Dr. Rainey also said that AMPAC membership now stands at a record 55,500 and that the organization had raised some $3.7 million in campaign funds in 1983-84; up from $2.4 million in the previous election cycle.
25. **AMA Membership Contest:** I am pleased to announce that the Florida Medical Association was awarded a first place trophy for states with over 11 delegates in the AMA new membership contest. Congratulations to Richard G. Connar, M.D. for producing the most new members in the group, and to Robert E. Windom, M.D. who was second in total number of new AMA members.

Report C of the Board of Governors

The Reference Committee commended the Board for its outstanding performance during this unusually difficult year and suggested particular action on the Recommendations as follows:

Recommendation No. C-1 was adopted as presented.

Recommendation No. C-2 was adopted as presented.

Recommendation No. C-3 was adopted as amended with several items considered separately;

Item B was not adopted.

Item K lines were deleted so the item reads as follows, "That the FMA Annual Meeting format be reduced from a five-day program (Wednesday to Sunday) to a four-day program (Thursday to Sunday)."

Item O was amended to read, "That the House of Delegates expressed strong support and approval for the recommendation that each specialty group recognized by the FMA have a voting delegate and alternate delegate in the FMA House of Delegates provided no delegate would have more than one vote, and each delegate be a member of the Florida Medical Association, and further, that the appropriate amendment to the FMA Bylaws be adopted to reflect this action. . ."

Report C of the Board of Governors was adopted as amended.

Report C of the Board of Governors

Frank C. Coleman, M.D., Chairman

On behalf of the Board of Governors, your Chairman is both proud and pleased to submit this report to the House of Delegates regarding the many activities of the Board of Governors and the Association's Councils and Committees during the past Association year.

The following report and the others throughout the Delegates' Handbook address the many vexing and difficult issues and problems currently being faced by medicine.

This past year has been a particularly difficult one, as we were faced with the tremendous challenge of a constitutional initiative campaign to resolve the professional liability crisis, which continues to plague physicians and the citizens of our state. We were also faced with the unexpected financial crisis effecting the Florida Physicians Insurance Reciprocal and the task of insuring the continuity of professional liability protection for those physicians who received their PLI coverage through the Reciprocal. It has also been a year of tremendous and sweeping change within your Association, changes I am confident will greatly enhance our ability to serve the needs of FMA members in the future. These important issues and changes are fully addressed in this report, as well as other sections of the Delegates' Handbook.

As I began my term as President on May 6, 1984, I extended a call for unity and participation; one profession — one Association — one future. We, as physicians, are in a time of great change, a change that is so dramatic and so sudden that it has dazzled many of us. It is clear that changing values and economic necessity are primarily responsible for this change. The public does not look upon doctors as it did a generation ago, and both business and government are rebelling against the high cost of health care. The question now is whether the cost of health care should be controlled by the competitive approach or by the regulatory approach. Unfortunately, with cost containment as the watchword, little is being said about the impact of cost containment on the quality of care.

Prospective payment for hospitals for Medicare patients using DRGs is now a reality and this same concept may well be extended to physicians. Our Legislature has been debating whether to give the Hospital Cost Containment Board the authority to regulate hospital rates for private patients. Physicians are being pressured to accept assignment on both Medicare and private patients. HMOs and PPOs are springing up like weeds.

There is increasing discussion about rationing of care and the ethical problems involved in care of the terminally ill.

In some specialties, we have an oversupply of physicians. This excess of physicians leads to intense competition for patients and makes participation very attractive in some of the non-fee-for-service delivery systems.

It is imperative that we remember that our obligation as physicians, as it always has been, is to provide quality medical care regardless of the changing times. This is a sacred trust and must be defended with all our strength.

The House of Medicine must make whatever adjustments should be made to defend this trust. The roof covering the House of Medicine must be broad enough for every physician to participate in the decision-making of the Florida Medical Association and in the implementation of these decisions.

Regardless of the specialty we practice, no matter what our mode of practice, we are all physicians first. We must work to further the best interests of that profession, knowing that none of us can succeed unless the profession succeeds.

The state Association, in cooperation with all of the county medical societies and specialty organizations, must have unity and represent all physicians. It must have programs, projects, policies and a philosophy that meet the needs and further the goals of all physicians, regardless of their individual attributes and circumstances.

What happens to one of us, happens to all of us. Some physicians cannot succeed while others fail. We all succeed together as physicians, or we all fail. Whatever differences exist, our response to problems of the future — legislative, economic, professional, scientific — must be focused toward the needs of all.

Your Chairman has been honored for having had the opportunity of working with the many dedicated physicians who have actively served during the past year on the Association's Councils and Committees. I would particularly like to thank those dedicated physicians with whom it has been my personal privilege and honor to serve on the Board of Governors. Each of your Board members have given freely of their time and talents and have kept the best interest of all physicians and the betterment of health care uppermost in their minds during this difficult year and have acted thoughtfully and wisely on your behalf.

Luis M. Perez, M.D., President-Elect
James G. White, M.D., Vice President
Henry M. Yonge, M.D., Secretary
Yank D. Coble Jr., M.D., Treasurer
J. Lee Dockery, M.D., Immediate Past President — 1986
Robert E. Windom, M.D., Past President — 1985
James B. Perry, M.D., Speaker of the House
Charles K. Donegan, M.D., AMA Delegate — 1985
Ernest G. Sayfie, M.D., At Large — 1985
Gerold L. Schiebler, M.D., District A — 1986
Kay K. Hanley, M.D., District B — 1987
Dick L. Van Eldik, M.D., District C — 1985
A. Frederick Schild, M.D., District D — 1988
T. Byron Thames, M.D., FPIR — 1985
Robert N. Webster, M.D., SMBE — 1985
Mr. Christopher A. Cunha, Student Member — 1985

To my successor, Dr. Luis Perez, I extend my best wishes and my optimistic belief that his year as President will be a deeply rewarding experience, as mine has been. With the level of leadership in Florida medicine and the many dedicated physicians who give of their time and talents in behalf of their colleagues, he can only succeed.

Major Activities

1985 Annual Meeting Format: The Board established the format for the 1985 Annual Meeting at the Diplomat Hotel, Hollywood, Florida, May 1-5, 1985, and approved as the scientific theme, "Quality Medicine in a Rapidly Changing Environment."

1985 FMA Leadership Conference: The 1985 FMA Leadership Conference was conducted Friday, Saturday, and Sunday, February 1-3 at the Tampa Airport Marriott Hotel. "Quality Medicine in a Rapidly Changing Environment" was the Conference theme which offered county medical society leaders and others a comprehensive look at a wide array of issues including legislation, public relations, medical economics, and hospital medical staffs. Several general sessions highlighted the Conference along with a special "Leadership Skills Seminar for Women Physicians" and an outstanding scientific section on "Clinical and Fundamental Approaches to Cellular Engineering."

Registered attendance total 329 physicians, Auxiliary members and other guests. Physician registrants represented 23 county medical societies and 11 FMA recognized specialty groups.

The following are highlights of the major issues addressed and examined at the Conference:

For the first time, the Leadership Conference offered a Leadership Skills Seminar for Women Physicians which was held on Friday morning and sponsored by the FMA Committee on Membership Development. The basic message conveyed by the various speakers was that women physicians have an unprecedented opportunity to be influencial and to assume leadership roles in organized medicine. The half-day Conference was planned and chaired by Kay K. Hanley, M.D., of Clearwater, and Margaret C.S. Skinner, M.D., both members of the FMA Committee on Membership Development.

Rufus K. Broadaway, M.D., Registered Professional Parliamentarian and author of *How to Run a Medical Meeting* discussed such topics as debating, taking a vote, determining a quorum, the types of motions, the order of business and general strategy carried out during a meeting. Assisting Dr. Broadaway at this well-attended and highly successful workshop was Franklin B. McKechnie, M.D.

Another workshop on "How to Deal with the Media" was conducted by Mr. Clarence Jones, of Marathon, nationally recognized broadcast journalist, investigative reporter, author, and the only reporter who has ever won three duPont-Columbia Awards (broadcasting's equivalent of the Pulitzer) in 1975, 1978, and 1981. Following his entertaining style, Mr. Jones involved the audience in interviewing techniques and coached physicians and auxilians on how to speak before the camera. "Try to get across just one thought and use just one sentence," he recommended. "Most on-camera responses are rarely over ten seconds, but you can easily get your message across in that period of time." Mr. Jones cautioned that before the camera one of the greatest mistakes made is attempting to say too much.

A Friday afternoon scientific section on "Clinical and Fundamental Approaches to Cellular Engineering" was presented by Robert A. Good, M.D., Ph.D., Professor of Pediatrics and Graduate Research Professor at the University of South Florida College of Medicine. The world-recognized immunologist, researcher, teacher and pediatrician presented an exciting program on recent developments in cellular engineering which are having an impact on the treatment of such diseases as cancer and diabetes. Dr. Good emphasized the future direction of research he will be conducting as Physician-in-Chief and Chairman of the USF Department of Pediatrics at All Children's Hospital.

Saturday morning began with welcoming remarks from FMA President Frank C. Coleman, M.D., who introduced the keynote speaker at the First General Session. Dr. Coleman welcomed Paul Starr, Professor of Sociology at Harvard University and author of the bestselling book *The Social Transformation of American Medicine*. Dr. Starr told the audience about the frustration the public is experiencing over the health care system. Much of the frustration and confusion is due to competition and the rapidly changing redistribution of services. Traditional boundaries between adjacent groups such as insurance companies, hospitals and physicians are becoming blurred. New suppliers are taking away patients from private physicians. Although hospitals still accept

individual patients from individual physicians, the same hospitals are getting more patients from so-called bulk purchases through a variety of prepaid plans. The future holds enormous corporate upheaval with the rapid growth of health care systems, the vertical integration of services into single organizations and diversification of traditional health care organizations into other health-related and non-health-related businesses.

The second General Session on Saturday afternoon included a stimulating presentation on Doctor-Patient Communications. Featured Speaker was David Pendleton, Ph.D., Professor at Kings Fund College in London. Dr. Pendleton's major theme was how physicians can improve their communication skills to produce more satisfied patients.

Leadership Conference participants had an opportunity to attend Workshops on Legislation, Public Relations, Medical Economics or Hospital Medical Staffs. Topics covered in these Workshops included:

Legislation
- "The FMA Legislative Mechanism"
- The Capitol Scene
- View From the Hill — How it Works in Washington
- Specialty Groups
- Communicating With the Legislature

Public Relations
- Public relations in medical practice
- External public relations' projects for county medical societies

Medical Economics
- Status of programs of the FMA Council on Medical Economics
- Current trends in health economics and organizations
- Recent activities of government in Medicare and Medicaid programs
- The impact of health care delivery changes on the individual physician

Hospital Medical Staffs
- Key issues facing hospital medical staffs on national and state levels
- Current trends of hospital medical staffs on the national level
- The state perspective of the Hospital Medical Staff Section and how the FMA Council on Hospital Medical Staffs will operate.

On Sunday, a President's Prayer Breakfast was held, featuring James Strange, Ph.D., Dean, College of Arts and Letters, University of South Florida. Dr. Strange spoke on "Biblical Meditation." At a General Session following the Breakfast, Senator Dempsey Barron (D-Panama City) discussed professional liability and tort reform as part of an FMA Legislative Briefing. Senator Barron began his presentation by asserting that the number one problem of this state and of this nation is the cost of delivery of health care. And further, that this problem is not limited to this nation, but crosses boundaries and oceans around the world. Senator Barron feels that the resolution in Florida is to get professional liability out of the tort system, and that the only probable way this will occur is through a constitutional amendment.

Senator Barron said that for the Legislature to resolve this issue, it would take the full active support of the Governor. The Senator revealed that he has a proposal which he will sponsor in the Senate, based on the Workers' Compensation approach. He made it clear that the likelihood of its passing both chambers of the Legislature was remote at best. He said that there are two kinds of damage awards: special and general. It is the general damage awards that result in the large sums of money that we have heard about in malpractice cases. Therefore, cases should be limited to special compensation. General damages would include "pain and suffering," which is compensated for whatever amount a jury considers to be equivalent to pain and suffering.

In summary, it is clear that Senator Barron has assumed a leadership role in trying to resolve the issue of malpractice, but he cannot do it alone. Moreover, he challenged the medical profession to use its power, and hammer home a resolution to the problem, which until now has been manipulated by the legal profession and not for the benefit of the patient or his family. With this political guidance, organized medicine must utilize its combined strength to remove this impediment to physicians attempting to improve the health status of their patients.

Board Actions of Major Importance

FMA Priorities 1984-85: The Board approved the following Association priorities for 1984-85. (A report on the status of the Association's activities in implementing the priorities will be included as Appendix C-1 to the Board of Governors Report C in the Delegates' Notebook.)

Membership

- The Association will continue to work toward a permanent solution to the professional liability crisis in Florida through legislative, judicial and constitutional remedies, as indicated.
- Develop programs to increase awareness among practicing physicians of the importance of maintaining a relationship with their patients which is responsive to their medical and emotion well-being and which fosters open communications between the patient and the physician.
- Develop, in cooperation with component county medical societies, the FMA Auxiliary, and FMA-recognized specialty societies, public relations programs designed to improve the image of organized medicine and the individual physician as perceived by the news media and the public including an awareness of the contributions that the medical community makes to society at all levels through the provision of quality

Clair Marie Callan, M.D., President, American Medical Women's Association, speaks at the Symposium for Women Physicians.

health care and through the continued pursuit of advancements in medical technology and procedures to improve quality and longevity of life.

- Continued emphasis on a comprehensive and ongoing media relations program implemented in cooperation with component county medical societies.
- Continued efforts toward implementation of a statewide Impaired Physicians Program with a full-time medical director.
- Continued efforts to develop among FMA members an awareness of their individual responsibility for becoming actively involved, through organized medicine, in the decisions that will be made by the Legislature and other governmental bodies affecting the mechanisms and the level of health care delivery in Florida and throughout the country including, but not limited to, health care financing and system of health care delivery; i.e., Health Maintenance Organizations, Individual Practice Associations, Preferred Provider Organizations, Diagnostic Related Groups, health care competition, utilization review, peer review mechanisms, and other cost containment initiatives.
- Develop an awareness among FMA members of the factors underlying the increases in the cost of health care and evaluate the physician's role in addressing the concerns regarding health care costs.
- Continue efforts to improve communication and cooperation regarding programs and activities of the FMA with component county medical societies, the membership directly, and FMA-recognized specialty societies including maximum development of the GTE Telenet Medical Information Network in Florida.
- Continue to monitor the current relationships of physicians, individually and collectively, with hospitals and other health care facilities with appropriate actions, when indicated, to ensure preservation of the role of the physician as having primary responsibility and authority for the management of patient care but with productive interaction with allied health groups.
- Membership development at the county, state and national levels to include medical student and house staff representatives.
- Encourage FMA members to exercise their individual responsibility for becoming actively involved in community affairs and the political process including legislation and political action activities.
- The FMA will continue to explore every avenue to assure that physicians are equitably reimbursed for the services that they render to government-sponsored health care programs including the Florida Workers' Compensation program. The Association, following the directive of the 1983 FMA House of Delegates, will continue its efforts to achieve equitable payment for health care services which recognizes regional differentials in those counties where the total cost of health care delivery is demonstrated to be higher than the average for the remainder of the state.

Programs

- Continue efforts to inform the public, the Legislature, and the judiciary of the facts regarding the critical need to resolve the professional liability crisis and the deleterious effect that this problem is having upon the patient/physician relationship and the cost and quality of health care in Florida.
- Creation of a public awareness of the high level of quality and availability of health care in Florida and the contributions that the medical community makes on an ongoing basis to the preservation and quality of individual life, the public's health, and to the cultural growth of the community at large.
- That the Association actively participate in a cooperative effort with the Legislature, appropriate governmental bodies, and voluntary groups in the development and implementation of meaningful and equitable programs to respond to the concerns of the continuing increase in the cost of health care delivery with the primary goal of ensuring the continued provision of the highest level of quality medical care within the private free enterprise system of health care delivery including:

  1. An objective assessment and reporting on the underlying causes of rising health care costs in Florida.
  2. An evaluation of the impact of health care costs on the public with particular emphasis on Florida's increasing elderly population, the designated medically indigent, the unemployed, business and industry.
  3. Informational programs for the purpose of advising FMA members, the public, the Legislature and other governmental bodies on the positive and negative aspects of innovative initiatives and programs designed to cut or contain the cost of health care, such as Preferred Provider Organizations, Health Maintenance Organizations, Individual Practice Associations, health care competition, utilization review programs, peer review mechanisms and other cost containment initiatives.

- The Association will continue to promote and participate in programs addressing emergency medical services, the health needs of the aging, substance abuse, public health and school health that impact upon the health and well-being of all Floridians including:

  1. The implementation of the first-year recommendation of the FMF Emergency Medical Services Project.
  2. Providing medical leadership in the implementation of the AMA Prescription Abuse Data Synthesis (PADS) model through direct involvement with the appropriate state agencies and assuring a program of identification and referral of impaired physicians to the Committee on Impaired Physicians.
  3. Focusing on the problems of toxic substances in the environment and their impact on public health.
  4. Developing and promoting a uniform, statewide preathletic participation physicial examination.

- The Association will increase its efforts to establish channels of communication and cooperation with voluntary health agencies, allied health groups, the Florida Hospital Association, medical professional organizations, senior citizen organizations and third-party carriers in order to create meaningful health care coalitions in Florida to address issues of mutual concern.
- Continue to work toward a cooperative relationship with other departments and agencies of state government in health care related issues.
- Seek direct physician participation at the policymaking level for health planning and other state-administered health care programs including the rulemaking process.
- The Association will continue to oppose vigorously the practice of medicine other than by medical or osteopathic physicians.
- The Association will strive to become the acknowledged leader in Florida in the promotion and coordination of scientific and educational medical activities including:

  1. Identifying physicians and non-physicians throughout Florida who have direct responsibility for the provision of continuing medical education activities and providing them with appropriate up-to-date information on CME and accreditation procedures and requirements.

2. The development of an FMA booklet on CME explaining the Association's program.
3. Providing assistance to county medical societies, specialty societies and hospitals relative to procedures and requirements for high-quality programs of CME.

- That pursuant to the actions of the FMA House of Delegates in May 1983, the Association, through the Florida Medical Foundation or other appropriate entity, apply for designation as the statewide peer review organization (PRO) in Florida as authorized under the Tax Equity and Fiscal Responsibility Act of 1982 (PL 97-248) for the purpose of promoting the efficient and economic delivery of health care services while assuring and promoting the quality of care rendered. It is the intent of the Association that, to the greatest extent possible, the FMF-PRO will through local county medical societies or their designated physician-established mechanisms implement the PRO activities at the local level. It is further the Association's intent that qualified physicians maintain primary responsibility and authority for the peer review process.

Public

- Continue to provide the public, governmental bodies and the news media with timely and responsive Association views on:

1. The seriousness of the problem of professional liability and cost of health care liability insurance in Florida and how it affects all segments of society.
2. Preventive health care educational programs.
3. Health of the public.
4. Standards for health care delivery and qualified health care professionals including health planning and qualified review of the quality and appropriateness of health care delivery.
5. The underlying factors of the cost of health care.
6. Alternative health care delivery systems.
7. Health care financing initiatives.
8. The role of government in health care delivery.

American Medical Association (AMA)

- Continue efforts for AMA membership development.
- Cooperative effort to coordinate programs and activities at all levels of the Federation.
- That the AMA be encouraged to make every effort to create a greater public awareness of the high level of quality and availability of health care in this country and the contributions that the medical community makes to society at all levels through the provision of quality health care and through continued pursuit of advancements in medical technology and procedures by physicians to improve the quality and longevity of life, and to the cultural growth of their community.
- Encourage the AMA to actively create an awareness among the Congress, other governmental bodies, and the public of the severe litigation problem in this country particularly the professional medical liability problem and the deleterious affect that it is having on the cost and quality of health care.
- The the AMA continue to address before Congress and other governmental bodies organized medicine's views on the standards for health care delivery and qualified health care professionals, the underlying factors affecting the cost of health care, the positive and negative aspects of innovative cost containment initiatives, and that the AMA continue to exert its full efforts to ensure the preservation of the country's private free enterprise system of health care delivery.

Issues

- Medical professional liability.
- Cost of medical care.
- Improving the patient/physician relationships and communication.
- Public awareness of the contributions of medicine to the quality of society.
- Continued opposition to any compulsory comprehensive national health insurance program.
- Opposition to the practice of medicine by other than medical or osteopathic physicians.
- Alternative health care delivery systems.

Awards

The Board voted to continue the following FMA awards for 1985:

Excellence in Medical Journalism
Medical Speakers Awards
Medical Malpractice Prevention Award
Harold S. Strasser, M.D., Good Samaritan Award

The Board further authorized that a special award be established for the FMA Awards For Excellence in Medical Journalism to be entitled, "The Best Of All Entries," in memory of Ernest R. Currie, Executive Vice President of the Duval County Medical Society from 1968 until his death in 1984; and further, that this Ernest R. Currie Memorial Media Award be awarded on an annual basis.

Good Samaritan Award: The Board selected two outstanding physicians as recipients of the 1985 Harold S. Strasser, M.D., Good Samaritan Award for humanitarian acts above and beyond the high standard of conduct normally expected of physicians. The awards will be presented at the First Meeting of the House of Delegates on Wednesday, May 1, 1985.

A.H. Robins Award: The Board reviewed nominations received from county medical societies and selected the recipient of the 1985 A.H. Robins Award "For Outstanding Community Service by a Physician." This award will be presented at the First Meeting of the House of Delegates on May 1, 1985.

Distinguished Layman Award: The Board selected the 1985 recipient of the Distinguished Layman Award. The appropriate citation, along with the criteria, will bc included in the Delegates' Notebook. This award will be presented at the First Meeting of the House of Delegates.

Certificate of Merit: The Board selected an outstanding physician for nomination to the House of Delegates to receive the Certificate of Merit for 1985 (the Association's highest honor of achievement). This nomination will be included in the Delegates' Notebook for approval by the House of Delegates.

Certificate of Appreciation: The Board selected a physician to be nominated to the House of Delegates as recipient of the 1985 Certificate of Appreciation. This nomination will be included in the Delegates' Notebook for approval by the House of Delegates.

Professional Liability
Reason '84 Campaign

The 1985 Legislative Session of the Florida Legislature convenes on April 2, 1985. Many crucial issues will be debated and voted on which affect all the citizens of Florida. Among these issues will be important health care legislation. The most important of these health issues remains the professional liability crisis in our state.

The FMA has been working to bring about the enactment of long-term tort reform through the legislative process since 1975. It appears that it is no mere coincidence that malpractice suits

against doctors began to escalate shortly after the Florida Legislature, in 1971, adopted a no-fault auto insurance law. The law stabilized auto insurance rates by restricting the large number of frivolous lawsuits being filed in the state as a result of auto accidents.

In 1975, the Legislature declared in a resolution that a malpractice crisis existed in Florida because of the sudden, sharp increase in suits against doctors. Premiums soared by as much as 300% in one year, causing major insurance companies to get out of the Florida market and leaving doctors virtually no place to buy liability insurance.

The Legislature responded positively that year with two key remedies: mediation panels were created to examine the merits of cases filed against doctors, and a statute was created permitting Florida physicians to create their own insurance company to provide doctors with protection they could not at that time purchase through commercial carriers.

The mediation panels, whose purpose was to hear all medical malpractice claims and determine if there was evidence of medical negligence, consisted of a doctor and two attorneys, including a circuit court judge.

The panel's findings did not restrict a citizen's right to a jury trial. The findings could, however, be admitted as evidence in a trial. In 1976, the Florida Supreme Court ruled that the panels were constitutional.

The panels, to the consternation of the trial attorneys, proved to be an effective deterrent to non-meritorious suits. During the nearly five years in which they operated (1976-80), the panels ruled in 93% of the cases that there was no actionable negligence on the part of the doctors being sued.

Significantly, the decisions were unanimous (3-0) in 81% of the cases mediated.

The panels were attacked on two occasions by plaintiffs' attorneys and were upheld. But on February 28, 1980, with changes in court personnel, the plaintiffs' attorneys' persistent efforts were rewarded when the Supreme Court reversed itself and held that the panels were unconstitutional. The disappearance of mediation panels paved the way for a flood of new cases over the next two years, with 40% more in 1981 than 1980 and 35% in 1980 over 1979. This resulted in an increase in insurance premiums to amounts up to $70,000 annually in the high risk specialties. By 1983, based on Florida Physicians' Insurance Reciprocal records, an average of one out of every four doctors in the state could expect to become involved in a malpractice claim.

Consumers of health care, our patients, are feeling the effects of this intolerable situation right where it hurts — in their pocketbooks. Obviously, they must pay the higher cost of insurance with higher fees, but just as important, they must pay the cost of "defensive medicine," a practice used more frequently by more doctors these days as a means of self-protection against lawsuits.

Because we face the prospect of being sued if something should go wrong, many doctors order tests and other procedures they might not deem essential. The best estimate is that 30 to 40% of all diagnostic procedures ordered by physicians are attributed to defensive medicine.

In his study of the amount health consumers could expect to save over a six-year period if Amendment Nine had passed, M.G. Lewis projected a savings of $12.6 billion in six years as a result of the decrease in the practice of defensive medicine.

In addition to being costly to health care consumers, the malpractice crisis has caused a serious deterioration in doctor-patient relationships. Most doctors, particularly the younger ones, are preoccupied with the possibility of being sued.

The ever present threat of a lawsuit affects the physician's practice in several ways. It creates an anxiety in which every patient may be viewed as a potential adversary and in which the physician has begun to picture himself as an inviting target. This dangerous state of affairs not only gives rise to the practice of defensive medicine, but can and does discourage doctors from performing procedures that are worthwhile and proven but also contain a significant degree of risk. For example, a 1983 survey by the Florida Obstetric and Gynecologic Society that same year showed 25% of these doctors had stopped delivering babies and another 30% planned to stop. Again, the chief reason was the high cost of insurance and the treat of lawsuits.

The *Herald's Tropic Magazine* reported this year that Dr. George Pickel, a 46-year-old Miami obstetrician who had delivered more than 5,000 babies, had given up his medical practice to become personnel director for a car rental agency. He made the move after being slapped by two lawsuits which his insurance company settled out of court although Dr. Pickel did not feel he was responsible. He was devastated by the lawsuits, his colleagues reported.

A *Topic* survey of hospitals in Dade and Broward counties also shows that the birth rate by Cesarean section is almost 50% higher than the national average. It was explained that doctors rarely are sued if they deliver by Cesarean section and the birth is imperfect.

In Clewiston, the local hospital has closed its maternity ward because local doctors have stopped delivering babies. Pregnant women in the area must now drive 60 miles to the nearest hospital delivery room.

In 1983, after a lengthy study by respected members of the medical and legal professions, the insurance industry and members of the Legislature, FMA recommended a legislative package to resolved this crisis on a long-term basis.

Nothing in these recommendations would have restricted a citizen's right to go into the courts to recover damages for malpractice. Never has the Florida Medical Association attempted, in its legislative recommendations or in the Amendment Nine proposal, to remove the responsibility for taking care of a patient who is injured because of the short-comings of a member of the profession. When accidents occur, they should be recognized and those injured should be compensated to the extent of their need so long as that need exists.

We are deeply concerned that in many cases there is no actual malpractice; nevertheless, the jury, with considerable compassion but without much of an understanding of medicine, will dole out ten and hundreds of thousands of dollars — even millions — to the plaintiff patient. The public will pay this eventually.

The FMA also strongly believes that there is something wrong with a system that frequently gives more money to the attorney than it gives to his injured client. The University Health Trust at Jackson Memorial Hospital in Miami reported that between 60 and 70% of all monies paid out for liability would wind up in the pockets of attorneys under their contingency fee system.

As widely reported in the media, the Legislature rejected in 1983 and again in 1984 the legislative package sponsored by FMA to resolve the crisis. We should say it was rejected by the Florida House, chiefly through the efforts of the House Speaker, a trial attorney, who refused to allow it to come to the floor for debate. The Senate, by contrast, passed the package both years by substantial majorities.

Unable to get the Legislature to act, and after years of exploring ways to solve the malpractice problem, the physicians of Florida and the Florida Medical Association decided to go directly to the people with this issue. The method of amending the State Constitution through petition and a vote of the people, when the Legislature fails to act, was provided for in a 1968 revised Constitution and strengthened in 1972 by an overwhelming vote of the people.

Florida doctors were likewise committed to pass on any and all of the savings resulting from the effects of Amendment Nine to our patients. This is not a simple commitment, but a solid moral commitment made for a very simple reason — doctors believed that action must be taken to help cut costs and protect

the quality of health care.

Passage of Amendment Nine would have accomplished three objectives in civil cases. It would have eliminated the doctrine of joint and several liability which currently puts the defendant at the risk of paying 100% of the damages awarded even though he or she may have had only a minor role in the incident.Secondly, the amendment would have placed a limit of $100,000 on the amount of noneconomic damages, monies awarded for pain and suffering and other intangibles. Thirdly, Amendment Nine would have also required judges to make prompt decisions (summary judgments) in any case where there is no disagreement over the facts of the case.

Nothing in the proposed amendment restricted or limited a citizen's right to sue for malpractice, and nothing prevented a person from recovering all economic losses — loss of wages and earning capacity — and all medical expenses, now and in the future.

Physicians in Southeast Florida have borne the major brunt of this malpractice crisis. They are forced to pay an average of 45% more for professional liability insurance than their colleagues in other areas of the state. South Florida obstetricians and neurosurgeons, two of the most crucially needed specialties, are now paying upwards of $70,000 annually for their insurance.

Plaintiffs'attorneys were particularly critical of the $100.000 limitation on noneconomic damages which would also affect other damage suits. They contended that it would discriminate against low income Floridians.

What these plaintiffs' attorneys were and still are concerned about, of course, is their own pocketbooks. They customarily receive from 35 to 60% of each award as a contingency fee and the pattern of jury awards in recent years has been increasingly large sums for noneconomic damages such as pain and suffering. It is not at all uncommon these days for the plaintiff attorney to make $1 million or more on a single case.

In seeking a limit on these noneconomic awards through Amendment Nine, FMA believes that society can no longer afford to enrich people due to exorbitant noneconomic awards which society pays for through increased medical costs. Increasing medical costs are what is hurting low income people the most.

Trial attorneys attempted to mislead Florida citizens through television ads that depicted a drunk driver being "let off the hook" for running over a child. Former Supreme Court Justice Fred Karl, who joined the Reason '84 Campaign as Executive Chairman, said that this was blatantly misleading. Drunk drivers, he pointed out, go to jail, pay fines and penalties, and must compensate those they hurt for medical bills and lost wages. In cases of this type of criminal negligence, victims could also collect unlimited punitive damages, Karl said. The $100,000 cap on noneconomic damages would not apply in these cases.

The law firm of Mahoney, Hadlow and Adams of Jacksonville, one of the state's oldest and most respected law firms, agreed with former Justice Karl. Engaged by FMA to research this question, the firm reported there is precedent in law to support Reason '84's position that punitive damages would not have affected tort cases.

The Florida Supreme Court has held that the intent of the framers of an amendment, as expressed in public debate, is evidence of the public's perception and intent when they vote to approve it. Reason '84 sponsors stressed in its literature and debate that the amendment would not restrict punitive damages. Reason '84 continued to stress this point in debates and advertisements. Our intent was clear and the issue had been adequately explored.

Was Amendment Nine "recklessly tampering" with the Constitution as critics claim? Since the Constitution was revised in 1968, it has been amended 28 times and an additional nine amendments were on the ballot November 6. Could all of those 28 additional amendments be described as reckless tampering?

Was this the first attempt to limit liability in Florida? No, in 1935 Florida's *Workers' Compensation Law* was passed. It protected workers by allowing them to be adequately compensated for medical expenses and lost wages for on-the-job injuries. But in exchange for this protection, the right of workers to file suit in courts is severely restricted. In 1979, the law was reformed to virtually eliminate attorney fees which were paid on top of awards to injured workers at a cost of millions of dollars annually. In 1971, the Florida Legislature enacted the state's first no-fault auto insurance law due to thousands of damage suits being filed annually that were not only clogging the court system, but driving insurance rates upward to an extent they had become an intolerable burden. The law restricts suits and has saved Floridians millions of dollars in insurance costs.

A key question Florida citizens should ask is this — Would there have been this avalanche of damage suits against doctors if the no-fault auto insurance law had not been approved by the Legislature? Would there be this many suits if attorneys would in some way censure the large number of their colleagues who encourage damage suits through television and newspaper ads? Advertisements that have helped produce a mentality in the population that for every harm, real or imagined, there must be a remedy of money.

The Panel for the Section on Chemical Dependency was moderated by E. Joan Barice, M.D., President, Florida Chapter, American Society on Alcoholism, Palm Beach Gardens. The panelists were, left to right: Roger A. Goetz, M.D., Medical Director, FMF Impaired Physicians Program, Jacksonville; Dolores A. Morgan, M.D., Director of Addiction Services, Mount Sinai Medical Center, Miami Beach; Richard J. Feinstein, M.D., Florida State Board of Medical Examiners, Miami; Dr. Barice; Deborah Miller, J.D., Practicing Attorney, Miami.

The malpractice system that is supposed to protect the public is now being abused and all of the citizens of Florida are paying the price in higher medical bills. The Florida Medical Association embarked on this campaign because Floridians wanted action immediately against the high cost of health care. Unfortunately, the Supreme Court said no to the citizens of Florida, and again for the second time in 1984, deprived the voters of Florida their basic right to vote on a proposition that was critical to Florida's welfare.

The development of Amendment Nine and the inclusion of three provisions in the FMA proposed constitutional amendment was the result of a thorough study of those tort reform proposals that offered the greatest possible potential for effectively helping to resolve the professional liability crisis that has plagued not only Florida but many other states for over ten years. The FMA received the counsel of many knowledgeable individuals in preparing the constitutional amendment, including a special ad hoc committee on professional liability, the Association's legislative and legal consultants, which include former members and leaders of the Florida Legislature, and constitutional attorneys. The Association also received valuable input from other states and individuals knowledgeable on the professional liability issue, as well as the well-documented experience of the Florida Physicians' Insurance Reciprocal. There was a careful indepth analysis of those elements crucial to effective tort reform relief, as well as a measuring of the inherent risk of each of these elements and the volatile political environment in which we were functioning, and the single subject requirements for constitutional initiatives were carefully reviewed. The FMA's legal counsel did caution that a pending decision (which had not been made) by the Florida State Supreme Court on the Proposition 1 tax reform proposal could affect the FMA amendment if that decision was adverse. However, it was also pointed out that previous decisions of the court relative to proposed constitutional amendments in which the court had determined that the single subject requirement had been met clearly supported the constitutional soundness of the FMA proposal. In removing Proposition 1 from the ballot, the court totally reversed itself from its previous rulings and so indicated. It should also be pointed out that the court's decision on Proposition 1 did not occur until long after the time when the commitment had been made to move ahead with the FMA's tort reform proposal.

As indicated, a decision to include three directly related provisions in the FMA's amendment was based on current Florida law and substantiated by previous rulings on the single subject issue by the Supreme Court. The constitutional amendment effort was unanimously approved by the House of Delegates and was carried out by the Board of Governors whose sole concern is to represent the best interests of the physicians of Florida and their patients. It was a bold step to resolve the professional liability dilemma that is having an increasingly devastating effect on the quality and cost of health care, and which if not stemmed will literally threaten the future continuity of care. If Florida could be successful in its efforts, it could well set the stage for long sought relief in many other states who, like Florida, have been thwarted in their efforts to bring about meaningful tort reform through the legislative process. The provisions included in Amendment Nine were crucial to the attainment of that goal. It was a sound proposal. This was substantiated by one of our most revered circuit court jurists in Florida, Judge Ben Willis, of Tallahassee. In response to the challenge to the amendment by the Florida Academy of Trial Lawyers, he ruled that not only did Amendment Nine clearly meet the single subject requirement for constitutional initiatives, but that it was "enlightening." As stated at the press conference following the Supreme Court's action in removing Amendment Nine from the ballot, the court's decision was clearly politically motivated and contrary to the overwhelming will of the voters of Florida as demonstrated by more than 630,000 signed and certified petitions, the greatest number in Florida history. To think that the court's action was not greatly influenced by the tremendous economic implications of Amendment Nine for a severely flawed tort system, is folly. We should not be dissuaded by nor gullible, to the disparaging post-mortems on Amendment Nine by some of our well-intended attorney friends. There were many positive results from the Campaign. There is a strong public awareness of the severity of the professional liability problem and support for its resolution such as has not existed in the past. The Governor and other legislative leaders have publicly acknowledged professional liability as a serious problem in our state and have expressed a willingness to work for effective and equitable tort reform. As evidence of this concern, the Governor has appointed a special task force to review the problem and to report its findings and recommendations. A special business coalition task force on the professional liability problem has also been actively addressing this issue. In addition, the Florida Bar has expressed its willingness to work with the FMA in seeking solutions and we have the continuing support of many allied organizations, as well as business and industry. We need only to examine the litigious society we are all languishing in to recognize the mortal flaws in our current tort system. No doubt the drastic changes necessary to resolve this issue pose many vexing problems, but drastic changes there must be. The public deserves nothing less.

While the Supreme Court's decision was a great disappointment and a set back, the Florida Medical Association remains determined to continue its fight for tort reform. In an emergency meeting of the FMA Board of Governors held on Wednesday evening, October 3, 1984, by telephone, the Board voted to immediately consider future actions for continuing efforts to resolve this crisis including possible legal actions and further legislative actions, as well as the constitutional initiative process, if that becomes necessary.

Determined that the Association continue to exert every effort to permanently resolve the professional liability crisis, the Board authorized:

1. That the FMA President immediately appoint a special Blue Ribbon Panel to be comprised of the Council on Legislation and other prominent individuals to define and recommend a statement of policy for future tort reform efforts that will include specific legislative recommendations, constitutional initiative recommendations, petitions to the Supreme Court, and report its findings to the Board of Governors at the earliest possible date;
2. That pursuant to the recommendations of the Blue Ribbon Panel, meetings be requested with the Governor, the Florida Bar and legislative leadership to obtain a concensus regarding a petition to the Supreme Court in respect to the contingency fee system;
3. That consideration be given to the feasibility of attempting to have petitions signed during and prior to the November 6 General Election that would include those appropriate constitutional amendments as recommended by the Blue Ribbon Panel;
4. That every effort be made to obtain a commitment from the Governor and/or legislative leadership to place on the Agenda for the special November Session of the Legislature, a resolution of the professional liability crisis subject to the development of a proposed legislative program.

Included as Appendix C-2 to Report C of the Board is an historical review of the professional liability crisis, and a summary of the Association's past and current activities to resolve the crisis.

In addition, as your President, I have met with Governor Graham, the President of the Senate, the Speaker of the House of Representatives, Committee Chairmen Barron and Gustafson, Insurance Commissioner Bill Gunter, and representatives of the hospital association, the insurance industry, the business community, the American Association of Retired Persons, the Florida

Bar Association, and the Florida Academy of Trial Lawyers. I have appeared as a witness before the two task forces that have been studying the professional liability problem over the past several months.

The FMA's professional liability legislative program will be finalized following submission of the report and recommendations of the Governor's Task Force on Medical Malpractice. The provisions to the included in the FMA's tort reform package are outlined in Board Report D, The Council on Legislation, (pink — Reference Committee IV).

Florida Physicians' Insurance Reciprocal

On Monday, May 7, 1985, the State Insurance Commissioner of Florida, armed with a court order, gave the Florida Physicians' Insurance Reciprocal (FPIR) 30 days in which to show cause why it should not be placed into receivership. The Department's action was based on the results of a triennial examination of the FPIR that raised grave concerns that the FPIR had a serious deficiency in its surplus and was in jeopardy of not being able to discharge its liabilities.

The Department sought to disallow retroactively certain assets of the FPIR including:

- The Reciprocal's purchase of surplus relief when it has been an industry practice for many years, and;
- Investment in high return limited partnerships which had been approved previously in principle by the Department.

Disallowing these assets would cause the FPIR to fall short of the level of assets required by Florida law for a domestic insurance carrier. The FPIR had 30 days in which to reconcile these differences with the Insurance Commissioner. This action by the Department shocked the leadership of the FMA and those physicians who receive their professional liability protection through the FPIR.

Your Board of Governors acted immediately to investigate the problems of the Reciprocal and began a strenuous effort to seek a solution that would assure physicians covered by FPIR continuity of professional liability protection with no lapse in coverage.

After over five months of intense effort, the FMA was successful in producing an ongoing physician-owned professional liability insurance program for FMA members. Insurance Commissioner Bill Gunter announced on October 19, that the Florida Physicians' Insurance Reciprocal plan for rehabilitation would be submitted to the Circuit Court in Tallahassee for approval on October 25. Under the plan, the Insurance Department would enter into a management contract with the Physicians Insurance Company of Ohio (PICO) to provide management for the FPIR until and after the completion of the rehabilitation phase on December 31, 1984.

The development of a successful rehabilitation plan for the FPIR was due to the cooperative efforts of the Insurance Commissioner and members of his staff, with FMA and PICO, and the many dedicated subscribers of the FPIR who felt it was important to continue our physician-owned professional liability insurance company.

In a hearing held January 3, 1985 in Tallahassee, Circuit Judge Charles E. Miner, Jr., terminated the rehabilitation of the Florida Physicians' Insurance Reciprocal and returned the company to its new management, the Physicians Insurance Company of Ohio (PICO). In terminating the rehabilitation, the Court found that the Receiver's Plan of Rehabilitation had been complied with, and the Reciprocal could be returned to its new management without further jeopardy to the insurer and its creditors, claimants, subscribers or to the public. The Board of Governors believes that the termination of the rehabilitation will remove the current cloud of uncertainty about the Reciprocal's future and will enhance the ability of the Reciprocal to gain subscribers and will assure the ability of the Reciprocal to regain its former position in the market as a financially sound and competently managed company. The FPIR will be coverted to a stock company at the earliest possible date in 1985. A report on the operations of the FPIR will be included in the Delegates' Notebook. (Appendix C-3).

The Board also reviewed in great depth the problems encountered by the Reciprocal and directed that a "Big Eight" national accounting firm be retained to conduct an in-depth review of the finances and operation of the company and report its findings to the Board at the earliest possible date, and further, that the findings of the review be reported to the FMA membership. This review was completed and mailed to the entire FMA membership on January 4, 1985.

Finance

Income / Expenditures, 1984: The Association had a total income of $3,233,608 during 1984 from all sources including the following:

Dues and fees	$2,685,593
FMA *Journal*	130,569
Directory and other publications	36,761
Technical Exhibits	10,100
Interest and Dividends	325,865
Special Services	21,526
Special Contracts	12,863
GTE/MINET Program	10,331
Total Income	$3,233,608

Total expenditures during the year were $3,532,344 in the following categories:

General Activities:	$1,111,356
Contract Services:	254,048
Administration:	678,694
Personnel:	1,472,736
Corporate Fund:	15,510
Total Expenditures:	$3,532,344

FMA Trust Fund: The House of Delegates in 1980, authorized the Board of Governors to establish a special trust fund for the current and future reserves of the Association, the initial funding coming from the approximately $600,000 profit from the sale of the headquarters building in Jacksonville. The Trustees of this fund are the three (3) immediate past living presidents of the Association, including the Immediate Past President who is an officer. The principal and interest of these funds accrue in this trust account which shall be established in the name of the Association in an escrow trust. The Trustees may release the funds upon request of the Board of Governors which indicates that an emergency exists which cannot be financed through regular income or assets of the Association. In the event the Trustees do not agree to release the funds, the Board of Governors may direct their release upon ¾ vote of the active members of the Board of Governors.

The net proceeds from the sale of the FMA property at 801 Riverside Avenue and the purchase of 760 Riverside Avenue left a net of $137,000 and, as directed by the Board, was placed in the reserve fund.

The first four annual principal payments on the mortgage held by the FMA on the 801 property of $286,394 were placed in this trust fund. The interest earned through December 31, 1984 in the fund was $118,070 and the total balance in the trust fund as of December 31, 1984, was $541,464.

1982 FMA Assessment: The House of Delegates in 1982 authorized, at the discretion of the Board, a $50.00 mandatory assessment of all FMA active members for professional liability.

The Board, at its meeting on August 8, 1982, determined the assessment was needed to carry out the Association's professional liability program. As of the date of this report, total funds collected have been $572,092 including interest earned of $24,340. Total amount of expenditures to date are $572,092.

1984 FMA Assessment: The House of Delegates at a special called meeting on January 28, 1984, unanimously approved a mandatory assessment of $300.00 for all regular active dues paying members of the FMA to be utilized for implementing the FMA professional liability program. The assessment was billed on March 12, 1984, to 11,673 active members for whom the assessment was mandatory and to 2,866 members in other classifications, who were invited to pay the assessment on a voluntary basis. As of the date of the report, 9,701 active members have paid the assessment for a total of $2,910,300. A total of 739 voluntary payments were received for a total of $217,910.

In compliance with actions of the House of Delegates, these funds have been utilized solely for the FMA professional liability program including The Reason '84 Constitutional Initiative Campaign. As of the date of this report $2,393,500 had been transferred to the Reason '84 account. The campaign received income from other sources as follows:

• Campaign donation from the AMA	$ 250,000
• Campaign advance of funds from AMA (repaid on March 29, 1985)	500,000
• Direct mail responses	167,840
• Other state medical associations	9,350
Total income / Reason '84	$3,320,690

Total expenditures for the campaign as of the date of this report totaled $3,319,357 leaving a balance of $1,333 in the Reason '84 account. The balance of funds in the assessment account was $279,926, and $1,333 in the Reason '84 account for a total balance of funds in the amount of $281,259. As of the date of this report, 1,560 FMA members had not paid the mandatory assessment for a total of $468,000. An updated report on the 1984 assessment will be included in the Delegates Notebook.

The Board has established May 9, 1985, as the final date for payment of the 1984 special assessment, and thereafter any member who has not paid will be dropped from the membership of the Florida Medical Association and his/her respective county medical society.

The Board reviewed the financial statements and proposed 1985 budget presented by the Treasurer and Executive Director. The Board approved the proposed budget for 1985 for the total anticipated income from all sources and expenditures in the amount of $3,372,500. In keeping with the policy established by the House of Delegates, $50.00 of each member's dues was budgeted to public relations and legislative activities.

The audit conducted by the Association's CPA firm of Harbeson, Beckerleg and Fletcher for the year ending December 31, 1984, is available for inspection by any member of the Association who may wish to review it.

Judicial Council

In compliance with the FMA Bylaws, the Board of Governors has considered nominations for terms expiring on the Judicial Council in 1985.

RECOMMENDATION NO. C-1

THAT THE HOUSE OF DELEGATES APPROVE THE NOMINATION OF O. FRANK AGEE, M.D., OF GAINESVILLE, FOR ELECTION TO AN ADDITIONAL FIVE-YEAR TERM ON THE JUDICIAL COUNCIL AS THE REPRESENTATIVE FOR DISTRICT A.

CMS and FMA Communications: The Board directed that every effort be made to improve communications with county medical society executives and to broaden their involvement in the activities of the Association.

Annual Conference of Executives: The Board authorized the FMA to sponsor an annual joint conference of the FMA Executives at a time and location to be determined, and that the Association pay for travel and lodging and expenses for all those executives who wish to attend.

Executive Director Advisory Committee: The Board authorized the Executive Director to appoint an advisory committee similar to that of the AMA to be comprised of five members including county medical society and state specialty group representation, and that membership on the committee be rotated as feasible to allow the broadest possible participation, and that this committee meet with the Executive Director at times of his descretion to provide input into the activities of the association and to discuss issues of concern to county medical societies and specialty groups.

AMA — GTE/MINET: The Board approved the recommendation that the FMA offer to provide component county medical societies and specialty groups with necessary equipment to have access to the AMA MINET Communications Network with the actual cost of the equipment to be reimbursed to the FMA either in the total amount or through monthly repayment, and further, that this equipment be made available to members of the Board of Governors during their time on the Board.

Resolution — Michael H. Lopez, Jr.: The Board expressed deep regret over the sudden and unexpected death of Mr. Michael Lopez, Executive Vice President of the Palm Beach County Medical Society, and adopted the following resolution:

Whereas, Mike Lopez met an untimely death on December 22, 1984; and

Whereas, Mike Lopez was a steadfast friend of organized medicine and to all physicians and physicians' families; and

Whereas, Mike Lopez worked untiringly for the Palm Beach County Medical Society making it one of the most respected and effective component medical societies; and

Whereas, Mike Lopez was a personal friend to many members of organized medicine; therefore be it

RESOLVED, That the Florida Medical Association pay an official tribute to Mike for his many contributions to organized medicine, and send a report of this action to his family in an expression of our deepest condolence.

Champus Program: The Board endorsed Blue Cross and Blue Shield of Florida, Inc. in its efforts to be designated as Administrator of the Champus Program in Florida.

FMA Councils and Committees

JUDICIAL COUNCIL

Grievance Procedures: The Board directed that the current grievance procedures being utilized by the FMA Judicial Council and county medical society grievance committees be submitted to the House of Delegates at its May, 1985 meeting for reaffirmation. (Appendix C-4)

COMMITTEE ON MEMBERSHIP DEVELOPMENT

Local Membership Development Committee: The Board requested all county medical societies to establish committees on membership and development with primary responsibility for membership recruitment and retention; and further, county medical societies are asked to consider appointing to these committees a medical staff representative from each hospital in their area, as well as women physicians and where appropriate, resident physicians and medical student members.

Invitation to Join Campaign: The Board authorized the FMA to participate in the American Medical Association "An Invitation to Join" program.

Women In Medicine Seminar: The Board approved a half day workshop on leadership training for women in medicine to be held in conjunction with the 1985 FMA Leadership Conference. This seminar was an overwhelming success and the Board has approved a similar program to be held as part of the 1986 FMA Leadership Conference.

Florida State Medical Association: The Board extended an invitation to the Florida State Medical Association to send an observer with Privilege of the Floor to future FMA Annual Meetings.

COMMITTEE ON BYLAWS

The Board of Governors authorized a total review of the FMA Bylaws to be carried out during the 1985-86 Association year.

RECOMMENDATION C-2

THAT THE HOUSE OF DELEGATES APPROVE AN AMENDMENT TO THE FMA BYLAWS TO PROVIDE FOR THE FOLLOWING CHANGE WITH RESPECT TO REFERENCE COMMITTEE COMPOSITION:

CHAPTER IV
HOUSE OF DELEGATES

Section 15. REFERENCE COMMITTEES

Item 2. REFERENCE COMMITTEE COMPOSITION.

Reference committees shall be appointed by the Speaker, in consultation with the President, from the members of the House of Delegates. Each committee shall consist of AT LEAST five members, of which THE MAJORITY shall constitute a quorum. These appointments shall be published in The Handbook for Members of the House of Delegates and shall be announced at the first session of the Annual Meeting of the House of Delegates. The Speaker shall designate one member of each reference committee as Chairman. Officers and members of the Board of Governors shall not serve on reference committees and the report of the Chairman of a Standing Committee or the Chairman of a Council shall not be referred to a reference committee of which he is a member.

This removes the restriction of the size of the reference committees.

(New language in Bylaws — ALL CAPS)

COMMITTEE ON PROGRAMS AND PRIORITIES

The Committee on Programs and Priorities was established by the Board of Governors for the purpose of advising the FMA Executive Committee, which serves as the Long-Range Planning Committee, regarding the future programs and priorities of the Association. The Committee was specifically charged with the responsibility of carefully reviewing the current programs and priorities of the Association to determine if they accurately reflect the best interests of the physicians of Florida and their patients, as well as the many complex issues facing medicine in Florida and the entire country.

The Committee held five regional meetings which were attended by its members and representatives of county medical societies in the geographic area. These meetings were held in Jacksonville, Pensacola, Orlando, Tampa and Miami.

Spirited discussion took place at each of the meetings, which indicated some dissatisfaction and frustration about many of the activities of the FMA. The Committee Report contained more than twenty recommendations, which were considered first by the Executive Committee and then by the Board of Governors.

The Board commended the Committee on Programs and Priorities for the outstanding manner in which they carried out their responsibilities and duties in respect to the Committee's report and recommendation.

RECOMMENDATION C-3

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING RECOMMENDATIONS OF THE COMMITTEE ON PROGRAMS AND PRIORITIES AS APPROVED BY THE BOARD OF GOVERNORS:

A. THAT THE FLORIDA MEDICAL ASSOCIATION BECOME MORE INVOLVED WITH MEDICAL EDUCATION AT ALL LEVELS FROM UNDERGRADUATE AND RESIDENCY TRAINING PROGRAMS, THROUGH CONTINUING MEDICAL EDUCATION FOR PRACTICING PHYSICIANS.

B. Item B was considered separately and not adopted by the House, and therefore was removed from Report C of the Board of Governors.

C. THAT THE FMA EXPAND ITS PUBLIC RELATIONS PROGRAM WITHIN THE FISCAL RESOURCES OF THE ASSOCIATION.

D. THAT THE FMA REAFFIRM THE GOALS PREVIOUSLY ADOPTED AT THE OCTOBER BOARD MEETING FOR THE COMMITTEE ON HEALTH MANPOWER AS FOLLOWS:
- **IDENTIFY THOSE ALLIED HEALTH GROUPS THAT ANTICIPATE EXPANDED ACTIVITIES THROUGH LEGISLATION OR REGULATORY MEANS.**
- **IF POSSIBLE, IDENTIFY THE GOALS OF EACH ALLIED HEALTH GROUP.**
- **DEVELOP AN ADEQUATE DATA BASE FOR USE BY FMA, THE STAFF, AND COUNCILS AND COMMITTEES FOR COMMUNICATING WITH ALLIED HEALTH GROUPS.**
- **DEVELOP A DATA BASE ON PHYSICIAN MANPOWER IN FLORIDA WITH IDENTIFICATION OF AREAS OF SHORTAGES AND WHAT STEPS ARE BEING TAKEN TO CORRECT THESE SHORTAGES.**
- **DEVELOP A ROSTER OF EXPERT WITNESSES WHO WILL BE AVAILABLE UPON SHORT NOTICE TO REPRESENT THE FMA AT LEGISLATIVE HEARINGS.**
- **COOPERATE WITH OTHER AGENCIES AND GROUPS TO REMOVE PROBLEMS WITH FOREIGN TRAINED HEALTH CARE PROFESSIONALS.**

E. THAT THE FMA ESTABLISH A MECHANISM TO ENHANCE LIAISON WITH VOLUNTARY HEALTH AGENCIES.

F. THAT A SINGLE COMMUNICATION BE DISTRIBUTED TO THE FMA MEMBERSHIP ON A MONTHLY BASIS IN LIEU OF THE FMA BRIEFS AND GRAY PAPER, SUBJECT TO EVALUATION OF EFFECTIVENESS IN ONE YEAR.

G. THAT FMA ACTIVELY PROMOTE THE INSTALLATION AND UTILIZATION OF THE GTE/MINET SYSTEM (COMPUTERIZED MEDICAL DATA BASES AND ELECTRONIC MAIL) WITH THE FMA FIELD OFFICES, COUNTY MEDICAL SOCIETIES AND SPECIALTY SOCIETIES WITH OFFICES.

H. THAT EACH YEAR AT THE FIRST SESSION OF THE ANNUAL MEETING OF THE HOUSE OF DELEGATES, THE TREASURER PROVIDE A WRITTEN REPORT ON THE ASSOCIATION'S FINANCES TO EACH MEMBER OF THE HOUSE OF DELEGATES, PRESENT A VERBAL EXPLANA-

TION OF THE REPORT, AND RESPOND TO QUESTIONS IN AN APPROPRIATE FORUM.

I. **REFERRED TO THE EXECUTIVE DIRECTOR FOR A REPORT BACK TO THE EXECUTIVE COMMITTEE ON THE FISCAL IMPACT OF THE RECOMMENDATION THAT THE FMA ESTABLISH A MEDICO-LEGAL HOT LINE TO ASSIST PHYSICIANS CONFRONTED WITH POTENTIAL MEDICAL-LEGAL DIFFICULTIES.** [See Board Report E [goldenrod], Reference Committee V, in the Delegates Handbook.]

J. **THAT THE FMA MOVE THE ANNUAL MEETING TO SEPTEMBER BY 1987 AND BEGINNING WITH THE 1986 ANNUAL MEETING, IF POSSIBLE, AND THAT A BUSINESS MEETING OF THE HOUSE OF DELEGATES BE HELD IN JANUARY OF 1986 OR 1987 IN ORDER TO FACILITATE THE TRANSITION TO THE SEPTEMBER ANNUAL MEETING. THE BOARD REFERRED BACK TO THE COMMITTEE FOR FURTHER STUDY IN CONSULTATION WITH THE COUNCIL ON SCIENTIFIC ACTIVITIES' RECOMMENDATIONS REGARDING THE FORMAT AND LENGTH OF THE ANNUAL MEETING.**

K. **THAT THE FMA ANNUAL MEETING FORMAT BE REDUCED FROM A FIVE-DAY PROGRAM (WEDNESDAY TO SUNDAY) TO A FOUR-DAY PROGRAM (THURSDAY TO SUNDAY).**

L. **THAT FMA CONTINUE ITS COOPERATIVE AND MUTUALLY ADVANTAGEOUS RELATIONSHIP WITH THE AUXILIARY, WHOSE ABILITY TO ASSIST IN THE AREA OF LEGISLATION, POLITICAL EDUCATION, CULTURAL, PHILANTHROPIC AND ANY OTHER MEANINGFUL ACTIVITY IS ESSENTIAL.**

M. **THAT FMA CONTINUE ITS EFFORTS TO COORDINATE THE LEGISLATIVE ACTIVITIES OF SPECIALTY SOCIETIES IN CONCERT WITH THE FMA LEGISLATIVE PROGRAM, SUBJECT TO THE UNDERSTANDING THAT THIS RECOMMENDATION IS BEING IMPLEMENTED THROUGH THE COUNCIL ON LEGISLATION.**

N. **THAT FMA OFFER TO PROVIDE FULL OR PART-TIME ADMINISTRATIVE SUPPORT, SUBJECT TO APPROPRIATE FINANCIAL ARRANGEMENTS, TO ALL SPECIALTY SOCIETIES REQUESTING SUCH, AND FURTHER, THAT THE FMA CHIEF EXECUTIVE OFFICER MEET REGULARLY WITH SPECIALTY GROUP STAFFS.**

O. **THAT THE HOUSE OF DELEGATES EXPRESSED STRONG SUPPORT AND APPROVAL FOR THE RECOMMENDATION THAT EACH SPECIALTY GROUP RECOGNIZED BY THE FMA HAVE A VOTING DELEGATE AND ALTERNATE DELEGATE IN THE FMA HOUSE OF DELEGATES, PROVIDED NO DELEGATE WOULD HAVE MORE THAN ONE VOTE, AND THAT EACH DELEGATE MUST BE A MEMBER OF THE FLORIDA MEDICAL ASSOCIATION, AND FURTHER, THAT THE APPROPRIATE AMENDMENT TO THE FMA BYLAWS BE ADOPTED TO REFLECT THIS ACTION:**

CHAPTER IV
HOUSE OF DELEGATES

Section 1. DESIGNATION AND COMPOSITION

The House of Delegates is the legislative and business body of the Association, and its members are the delegates officially elected by the component societies AND SPECIALTY SOCIETIES in accordance with the provisions of these Bylaws, one member of the Hospital Medical Staffs Council appointed in accordance with the provisions of these Bylaws, and the Speaker and Vice Speaker of the House.

Section 6. DETERMINATION OF DELEGATES

Each component society shall be entitled to select annually and to send to each meeting of the House of Delegates one delegate for every forty active members of the Association within that society, and one for any fraction over and above the last complete unit of forty, as shown on the Association's records on December 31 of the preceding calendar year, provided that each component society holding a charter from the Association should be entitled to at least one delegate.

The student members of a component medical society within whose jurisdiction a school or college of medicine is located shall be entitled to select annually one delegate. This delegate must be approved by the county medical society and will be in addition to those chosen to represent regular members as provided elsewhere in these Bylaws.

EACH SPECIALTY SOCIETY RECOGNIZED BY THE FMA SHALL BE ENTITLED TO SELECT ANNUALLY AND SEND TO EACH MEETING OF THE HOUSE OF DELEGATES ONE DELEGATE WHO SHALL BE ENTITLED TO ONE VOTE. NO DELEGATE MAY REPRESENT MORE THAN ONE ORGANIZATION ENTITLED TO REPRESENTATION IN THE HOUSE OF DELEGATES.

The House of Delegates shall be limited as nearly as possible to a maximum of 250 regularly elected members from county medical societies, and one student delegate from each component society in whose jurisdiction a college or school of medicine exists. The Board of Governors shall automatically determine the ratio of delegates to active members to accomplish this limit of the membership of the House.

The House of Delegates shall have the power to determine its own membership and may by three-fourths vote of those delegates present in official session refuse to seat any delegate or alternate delegate.

Section 12. ALTERNATE DELEGATES

Each component society shall select alternate delegates corresponding in number to the delegates to which it is entitled, and shall designate to the Secretary of the Association the order in which they are to serve. EACH SPECIALTY ENTITLED TO HAVE A DELEGATE SHALL BE ENTITLED TO SELECT ONE ALTERNATE DELEGATE TO SERVE WITH ITS DELEGATE.

Each alternate not seated as a delegate at the Annual Meeting shall continue to serve as an alternate until the next Annual Meeting and for all interim or called meetings between Annual Meetings, unless the component society by certification of its President or Secretary duly designates a different alternate.

A qualified alternate delegate may be seated for a delegate who is unable to attend the Annual Meeting or any session of the House of Delegates. The component society may seat an alternate delegate for the delegate provided that the alternate delegate deposits with the Credentials Committee a certificate signed by the President or Secretary of the component society stating that the alternate has been properly selected to serve. An alternate who has been seated at any single session of the House of Delegates shall serve throughout that session and may not have his place taken by any other delegate or alternate provided further, that once an alternate has been seated for a delegate during any session of the House of Delegates, that alternate shall be the only alter-

nate thereafter eligible to serve for that particular delegate at subsequent sessions of the House of Delegates during the Annual Meeting.

P. APPROVED AS AMENDED THE RECOMMENDATION REGARDING THE COMPOSITION OF THE FMA BOARD OF GOVERNORS:

- **THAT FUTURE VACANCIES ON THE BOARD OF GOVERNORS FROM EACH MEDICAL DISTRICT BE ELECTED BY THE HOUSE OF DELEGATES FOR A TERM OF FOUR YEARS BEGINNING IN 1986.**
- **THAT THE OFFICE OF SECRETARY AND TREASURER NOT BE COMBINED.**
- **THAT A RESIDENT PHYSICIAN WHOSE RESIDENCY STATUS WILL NOT EXPIRE BEFORE COMPLETION OF THE ELECTED TERM BE ELECTED BY THE HOUSE OF DELEGATES FOR A TERM OF TWO YEARS AND THAT SUCH PHYSICIAN HAVE A VOTE ON THE BOARD.**
- **THAT A MEDICAL STUDENT BE APPOINTED TO THE BOARD BY THE PRESIDENT FOR A TERM OF TWO YEARS BEGINNING AT THE CONCLUSION OF THE CURRENT MEDICAL STUDENT TERM AND THAT THIS POSITION BE ROTATED CONSECUTIVELY AMONG THE THREE MEDICAL SCHOOLS, AND FURTHER, THAT THE POSITION HAVE A VOTE ON THE BOARD.**
- **THAT THE REMAINING COMPOSITION OF THE BOARD OF GOVERNORS, IN RESPECT TO THE AMA DELEGATE POSITION AND ADVISORY POSITIONS, REMAIN AS CURRENTLY PROVIDED FOR IN THE FMA BYLAWS.**
- **THAT THE AT LARGE POSITION OF THE BOARD OF GOVERNORS BE RETAINED AND APPOINTED BY THE PRESIDENT FOR A ONE-YEAR TERM.**

WITH THE ABOVE CHANGES, COMPOSITION OF THE FMA BOARD OF GOVERNORS WOULD BE: PRESIDENT; PRESIDENT-ELECT; VICE PRESIDENT; SECRETARY; TREASURER; TWO IMMEDIATE PAST-PRESIDENTS; ONE OF THE DELEGATES TO THE HOUSE OF DELEGATES TO THE AMA (APPOINTED BY THE PRESIDENT); ONE REPRESENTATIVE FROM EACH MEDICAL DISTRICT (ELECTIONS BEGINNING IN 1986); RESIDENT PHYSICIAN; MEDICAL STUDENT; AND AN AT LARGE APPOINTMENT BY THE PRESIDENT (ALL ADVISORY MEMBERS APPOINTED AS CURRENTLY PROVIDED IN THE BYLAWS); AND FURTHER THAT THE FOLLOWING AMENDMENT TO THE FMA BYLAWS BE ADOPTED TO REFLECT THESE ACTIONS:

CHAPTER V
ELECTIONS

Section 1. ELECTION AND TERM OF OFFICE

All officers shall be elected annually by the House of Delegates, and shall serve until their successors are elected and installed.

MEDICAL DISTRICT REPRESENTATIVES TO THE BOARD OF GOVERNORS SHALL BE ELECTED BY THE HOUSE OF DELEGATES FOR A TERM OF FOUR YEARS BEGINNING WITH DISTRICT A IN 1986; DISTRICT B IN 1987; DISTRICT C IN 1988 AND DISTRICT D IN 1989 AND THEREAFTER AS TERMS EXPIRE.

A RESIDENT PHYSICIAN SHALL BE ELECTED BY THE HOUSE OF DELEGATES TO SERVE AS A MEMBER OF THE BOARD OF GOVERNORS FOR A TERM OF TWO YEARS BEGINNING IN 1986 AND THEREAFTER EVERY TWO YEARS.

Section 2. ELIGIBILITY

Any active member in good standing is eligible for any office, ~~provided that he meets the provisions set forth in the Bylaws.~~ PROVIDED THAT ONLY RESIDENT MEMBERS IN GOOD STANDING AND WHOSE RESIDENCY STATUS WILL NOT EXPIRE BEFORE COMPLETION OF THE ELECTED TERM SHALL BE ELIGIBLE FOR THE RESIDENT POSITION ON THE BOARD OF GOVERNORS AND FURTHER PROVIDED THAT ANYONE SEEKING AN OFFICE OTHERWISE MEET THE PROVISIONS SET FORTH IN THE BYLAWS.

Section 4. NOMINATIONS

Nominations for officers AND MEMBERS OF THE BOARD OF GOVERNORS of the Association and delegates to the House of Delegates of the American Medical Association shall be made from the floor of the House of Delegates by a member of the House. All active members of the Association are eligible for nomination. Nominating and seconding speeches shall be limited to a maximum of two minutes.

Section 5. TIME AND PLACE

The election of officers and MEMBERS OF THE BOARD OF GOVERNORS of the Association and delegates to the House of Delegates of the American Medical Association shall be held during the final session of any meeting of the House of Delegates. Only seated delegates shall be eligible to vote.

CHAPTER VII
BOARD OF GOVERNORS

Section 1. COMPOSITION

The Board of Governors shall consist of the FOLLOWING MEMBERS WHO SHALL HAVE BEEN ELECTED BY THE HOUSE OF DELEGATES: President, President-Elect, Vice-President, Secretary, Treasurer, the two Immediate Past Presidents, ~~one of the delegates to the House of Delegates of the AMA (who shall be appointed by the President), and five members appointed by the President. The President shall appoint one member from each of the four medical districts with staggered terms, and thereafter they shall be appointed for four years as each term expires; he shall also appoint each year one member at-large for a term of one year.~~ ONE REPRESENTATIVE FROM EACH MEDICAL DISTRICT, AND A RESIDENT PHYSICIAN. IN ADDITION TO THE ABOVE, THE BOARD OF GOVERNORS SHALL CONSIST OF THE FOLLOWING MEMBERS WHO SHALL BE APPOINTED BY THE PRESIDENT: A MEDICAL STUDENT FOR A TERM OF TWO YEARS, PROVIDED HIS POSITION SHALL BE ROTATED CONSECUTIVELY AMONG THE THREE FLORIDA MEDICAL SCHOOLS; AN AT LARGE MEMBER FOR A TERM OF ONE YEAR; ONE OF THE DELEGATES TO THE HOUSE OF DELEGATES OF THE AMA FOR A TERM OF ONE YEAR.

The President shall designate, with the approval of the Board, one member to serve as a Public Relations Officer.

The Board, at its descretion, may select to serve on the Board of Governors in an advisory capacity, for a term of one year each, a representative from the Florida Department of Health and Rehabilitation Services, from the State Board of Medical Examiners, and from the Board of Directors of the Florida Physicians' Insurance Reciprocal, all of whom must be members of the Association.

The Speaker of the House of Delegates shall be an advisory member of the Board of Governors.

(~~Deleted language~~ — NEW LANGUAGE)

Report F
Supplement to Report C
of the
Board of Governors

Supplemental Report F of the Board of Governors was adopted.

Recommendation No. F-1 was adopted.

Report F
Supplement to Report C
of the
Board of Governors

Frank C. Coleman, M.D., Chairman

Committee on Membership and Discipline

In compliance with the FMA Bylaws, the Board of Governors considered nominations for terms expiring in 1985 on the Committee on Membership and Discipline.

RECOMMENDATION NO. F-1

THAT THE HOUSE OF DELEGATES APPROVE THE FOLLOWING NOMINATIONS FOR ELECTION TO THE COMMITTEE ON MEMBERSHIP AND DISCIPLINE FOR THE TERMS INDICATED:

DISTRICT 1:	**RUFUS THAMES, M.D. (89)**
DISTRICT 2:	**HERBERT E. BROOKS, M.D. (89)**
DISTRICT 3:	**JOE C. EBBINGHOUSE, M.D. (89)**
DISTRICT 4:	**BRUCE R. WITTEN, M.D. (89)**
DISTRICT 5:	**JAMES E. QUINN, M.D. (89)**
DISTRICT 6:	**RANDALL JENKINS, M.D. (89)**
	SAMUEL L. RENFROE, M.D. (89)
DISTRICT 7:	**JEFF W. HARRIS, M.D. (89)**
DISTRICT 8:	**ROYCE HOBBY, M.D. (89)**
DISTRICT 9:	**BETTIE R. DRAKE, M.D. (89)**
DISTRICT 10:	**JAMES D. MORGAN, M.D. (89)**
DISTRICT 11:	**E.J. VANN, M.D. (89)**
	RICHARD N. BANEY, M.D. (89)
DISTRICT 12:	**REGINALD J. STAMBAUGH, M.D. (89)**
DISTRICT 13:	**MARTIN F. MIHM, M.D. (89)**
DISTRICT 14:	**JAMES F. SMITH, M.D. (89)**
DISTRICT 15:	**ROBERT J. BRENNAN, M.D. (89)**
DISTRICT 16:	**JOSE F. LANDA, M.D. (89)**
DISTRICT 17:	**MAURICE H. LASZLO, M.D. (89)**
DISTRICT 18:	**RICHARD M. FLEMING, M.D. (89)**
DISTRICT 19:	**LINDA A. MARRACCINI, M.D. (89)**

PROFESSIONAL LIABILITY

The following is a status report on tort reform proposals currently under consideration by the Florida House of Representatives and the Senate, and the FMA's position and activities relative to each of these proposals. Any late developments on the professional liability issue will be distributed to the House of Delegates in a Supplemental Report at the Annual Meeting.

Governor's Task Force

The Governor's Task Force has concluded its deliberations and presented its final report to the Governor. The key recommendation of the Task Force involves an arbitration proposal for claims resolution. The proposal essentially would establish a requirement whereby a defendant in a medical malpractice action would have 90 days from the date the complaint is filed, to choose either binding or non-binding arbitration. The binding arbitration provision would be triggered if the defendant elects to admit "financial responsibility." Both parties would be required to participate and the claim would be submitted to arbitration on the issue of damages. If the defendant does not accept financial responsibility, the parties then submit their dispute on the issues of liability, damages, apportionment of responsibility among defendants to non-binding arbitration. If any of the parties reject the arbitration decision, certain penalties would be assessed against the rejecting party if they fail to improve their position at the subsequent trial.

Other key provisions of the Task Force Report involve the following:

- Mandatory Professional Liability Insurance
- Encourage Risk Management programs
- Increased authority for the Department of Professional Regulation in respect to investigation and discipline of licensed physicians.

At this time no specific legislation has been introduced to embody all of the Task Force recommendations. However, it is anticipated that certain of the recommendations will be amended into bills that are currently moving through the House and Senate.

The Barron Proposal — A Contract Mechanism for Resolution of Medical Malpractice Disputes

Senator Dempsey Barron (D-Panama City) has introduced in the Senate his revised bill in respect to an alternative, non-tort system for resolution of medical malpractice claims, Senate Bill 1030. Thirteen other Senators have signed the bill as co-sponsors.

The basic elements of the legislation are to preserve the threshold issue (breach of standard care), but it is settled by a judge rather than a jury. It proposes that the case be approached as one in contract rather than in tort. But once the obligation to pay damages has been established this proposal is much more predictable and forthright than the current system.

First, the bill provides reimbursement for all necessary and customary medical expenses. It also provides for rehabilitation benefits. All of this is designed to heal the person who is injured and to minimize the effects of the medical incident.

If the medical incident causes disability that lasts more than seven days there are specified temporary benefits and specified permanent benefits that are objective and that can be calculated up front, because they are based on the earning history of the injured person. They relate directly to the economic loss resulting from the medical incident and are designed to replace everything that was lost.

In addition, there are impairment benefits that can be as high as $100,000. These benefits are based upon a determination of the degree of disability the permanent injury causes to the plaintiff.

Finally, if death results, there are specific, identifiable death benefits for those who were dependent upon the deceased. There is no provision in the bill for general or non economic damages.

The bill purports that a person who is the victim of a medical incident will be much better off under the proposal than under the present tort system. If the right to damages can be established, he won't have to roll the dice to see whether he is undercom-

pensated or overly compensated. He won't have to share his award with his attorney (attorney's fees are in addition to the award) and the benefits will be paid forthwith. Moreover, the benefits are designed to **fairly** compensate the injured person for the adverse effects of the incident for so long as those adverse effects persist.

FMA has been working with Senator Barron to refine the bill and address the technical problems. It is anticipated that this bill, along with a bill introduced by Senator Mattox Hair (D-Jacksonville), will be the key pieces of legislation dealing with malpractice moving through the Senate.

House Proposed Sub-Committee Bill (PCB) 85-2 by Representative Art Simon (D-Dade)

On April 4, 1985, Representative Art Simon introduced PCB 85-2 which has been termed the "Comprehensive Medical Malpractice Reform Act of 1985." The bill proposes reform in three areas:

a. Claims prevention;
b. Claims resolution; and
c. insurance.

The following is a summary of the bill as prepared by the Committee staff:

"The prevention reform imposes liability on hospitals and required them to monitor the quality of their medical staff. Increased HRS overview of risk prevention programs supplements this effort. The 90-day presuit screening process and limitations on attorneys' fees (contingent fee sliding scale) highlight the claims resolution reforms. The imposition of mandatory malpractice insurance and the premium caps established in the JUA are designed to discourage doctors from practicing outside their areas of insured expertise while providing guaranteed access to affordable malpractice insurance.

Major points include triggered review of negligent physicians, increased risk management requirements, imposition on hospitals of responsibility for medical staff negligence, creation of a guaranteed maximum medical malpractice insurance premium, requirement of mandatory financial responsibility for certain doctors, and establishment of methods for case settlement and arbitration. The purpose is to reduce the societal costs of medical malpractice."

The FMA has met with Rep. Simon and has had an opportunity to present its recommendations in respect to the bill to Rep. Simon's Subcommittee. The key FMA recommendations for revision are as follows:

1. In respect to the section of the bill dealing with alternative methods of payment of damage awards, we recommend that the threshold be reduced to $500,000 for all damages and that the court be required to enter a judgement ordering the damages for future losses to be paid by periodic payments upon the motion of either party subject to the award meeting the other requirements of the section.
2. We recommend that the Committee consider revising the section of the bill dealing with presuit screening period and offers for admission of liability to provide for the defendant to foreclose the claim by offering, within 90 days of the notice provision contained in the bill, to pay the claimant's net economic loss, consisting of medical expenses and wage loss, and in addition, the defendant will be required to pay the claimant's attorney a reasonable attorney's fee. The proposal would obligate the claimant to accept payment of the net economic loss in total satisfaction of his personal injury claim in all cases except those in which the defendant intentionally inflicted injury or in which an injury caused permanent total disability. We recommend that the provision include incentive to encourage a defendant to offer to pay for the claimant's nct economic loss. In order to do this, we would recommend such necessary incentive include where the defendant who refuses to pay a claimant's net economic loss within the prescribed time period, would not be able to interpose any defense based upon the claimant's fault in the ensuing trial. We believe the provision could also provide that once the the claimant has established a prima facie case of the defendant's liability, the burden of persuasion would shift to the defendant. In addition, at the claimant's option, the case could be placed on an expedited trial calendar; and finally, the incentive could provide for an award of court costs and attorney fees to the successful claimant.
3. We recommend the section of the bill dealing with a modification of joint and several liability be revised to include the provisions contained in the bill submitted to Representative Sam Bell, i.e., House Bill 622, as that bill would be modified to medical malpractice actions. (Rep. Bell's bill abolishes the doctrine of joint and several liability.)
4. We recommend the section of the bill dealing with the liability of health care facilities for the negligent acts or admissions of their medical staff and personnel be stricken.
5. We recommend that the section of the bill dealing with the establishment of a special risk category, which includes a premium cap on rates paid by physicians, be stricken from the bill.
6. We recommend that the section of the bill dealing with engaging in unnecessary diagnostic testing and penalties provided therefore be stricken from the bill.
7. We recommend that the section of the bill dealing with financial responsibility for health care providers, i.e., mandatory insurance coverage of $1 million per claim with a $3 million aggregate be stricken from the bill and language substituted that would allow for hospitals to require professional liability insurance for those medical staff personnel who work in the hospital.
8. We recommend that the section of the bill dealing with the authority of the Board of Medical Examiners to require 50 hours of continuing medical education be amended to provide that this provision may be satisfied by enrollment in a similar program under the auspices of the American Medical Association and/or the Florida Medical Association.

Senate

FMA members have been requested to contact members of the Senate urging their support for SB 1030 (by Barron and others) which provides a contract mechanism for resolving medical malpractice claims through judicial hearing, as an alternative to the current inefficient tort system. (The principles in Senator Barron's bill are consistent with the concepts for tort reform approved by the Board of Governors at its January 1985 meeting as reported in Dr. Coleman's *President's Memo* dated March 27, 1985.)

House

FMA members have also been requested to contact members of the House of Representatives urging them to support changes to the House Sub-committee proposal that will provide relief to the geometric increases in and frequency of claims. Specifically, the current draft of the bill does not contain any limitations on noneconomic losses, an effective structured payout provision, not abolition of the doctrine of joint and several liability, all of which are essential in order to favorably impact on current cost of the system. (The FMA's recommended amendments to the proposed House Subcommittee bill would substantially bring it into conformity with the FMA's position for legislative tort reform.)

1984 House of Delegates Referrals

The Board reviewed the proceedings of the House of Delegates and items requiring additional study and/or action were referred to the appropriate councils and committees. Some matters required Board action only. Individual actions regarding the policies of the House of Delegates appear in the various council and committee reports as well as in this and other reports of the Board of Governors in the Delegates' Handbook.

RESOLUTION 84-11
Uniform Medicare Reimbursement Schedule
Capital Medical Society

The resolution below was not adopted by the House of Delegates but was referred to the Board of Governors for review:

RESOLVED, That the Florida Medical Association take all measures necessary to seek a uniform Medicare reimbursement schedule for the state of Florida, and insofar as possible, for the nation as a whole.

Policy of the AMA: The policy of the American Medical Association (AMA) is that any reimbursement program should be paid for on the basis of the usual, customary, and prevailing fees of physicians which vary by geographic location. The three most recent recommendations of the AMA in support of this policy are contained in the AMA proceedings: Council on Medical Service Report D-1983, Annual; Council on Medical Service Report B-1983, Interim; and Council on Medical Service Report A, June, 1984.

Florida Requirements: The four Medicare charge areas for the State of Florida are grouped by counties according to a methodology mandated by the Health Care Finance Administration (HCFA). The HCFA formula includes the historical physician charges for a locality and the customary, usual, and prevailing charges which vary not only in Florida but throughout the United States.

Congressional Activity: The Office of Technology Assessment (OTA) of the U.S. Congress is currently examining alternative Medicare reimbursement mechanisms, which include negotiated fees, prepaid capitation, in addition to the current customary, usual, and prevailing method. The OTA is scheduled to submit its findings in July to a reactor panel. The findings of the OTA and the recommendations of the reactor panel will then be submitted to Congress. The alternatives being examined do not necessarily entail a uniform system.

The FMA will closely monitor the activity and recommendations of the OTA and of the reactor panel and other Congressional activity on this subject. Current HCFA requirements, however, preclude Florida from altering the present arrangement for Medicare reimbursement in the state.

RESOLUTION 84-14
Florida Medical Association
Responsibility of Quality of Life Legislation
Volusia County Medical Society

The resolution below was not adopted by the House of Delegates but was referred to the Board of Governors.

RESOLVED, That the Florida Medical Association be instructed to utilize its political influence and become involved in legislation which indirectly, as well as directly, affects the quality of life for the people of the state of Florida.

Quality of Life Legislation: In response to this resolution, the FMA is specifically supporting three legislative proposals directed toward improving the quality of life for residents and visitors to Florida. They are: Alzheimer's Disease; Drinking Age; and Seat Belts. The Alzheimer's Disease legislation would create an advisory committee composed of seven members appointed by the Governor to make recommendations to the Department of Health and Rehabilitative Services (HRS). The proposed legislation currently under consideration by the Legislature would also create the Alzheimer's Disease Research Trust Fund and provides that HRS shall contract for three specialized model day care programs in the state. The Drinking Age bill would prohibit the consumption or possession of alcoholic beverages by anyone under the age of 21. Seat Belt legislation as proposed in one bill would require the operator of a private passenger motor vehicle to wear safety seat belts. Another bill would require all passengers to wear safety seat belts. Another bill would require all passengers in a private passenger motor vehicle to wear safety seat belts. Each of these legislative proposals aims to improve the quality of life by addressing the problems of Alzheimer's Disease victims and their families, by raising the drinking age to a more mature minimum age, and by ensuring that motor vehicle operators and their passengers are protected from the fatal or crippling effects of being in an accident without wearing a seat belt.

Community Outreach Program: The Board of Governors further approved of a recommendation submitted by the Council on Legislation aimed at improving the image of physicians as community leaders and thereby enhancing the FMA's ability to demonstrate concern about the health needs of all people through the development of Community Outreach Programs. This recommendation calls for the Board of Governors to approve the development of suggested community outreach programs to be implemented through county medical societies and hospital medical staffs as a means of creating a base for improving the communications for FMA activities. In approving this recommendation it was noted that in light of existing negative legislative and public attitudes towards organized medicine, it was felt by the Council on Legislation that the FMA should encourage physician members to be more involved in local community activities. A community outreach program should therefore be developed and coordinated through the leadership of the county medical societies and the chiefs of staff of hospitals. The positive public relations benefits generated from such an effort would substantially assist in building the base for enhancing the FMA's relationship with the Legislature.

RESOLUTION 84-4
Occupational Licenses
Dade County Medical Association

The resolution below was not adopted by the House of Delegates but referred to the Board of Governors for review.

RESOLVED, That the Florida Medical Association sponsor statewide legislation which would require all counties and municipalities in Florida to examine and validate a current and active state medical license before issuing a local occupational license to any physician who seeks to maintain an office for the practice of medicine.

Proposed Legislation on Occupational Licenses: The new Health Care and Insurance Committee of the Florida House of Representatives in its proposed Comprehensive Medical Reform Act of 1985 specifically provides for provisions that would meet the objectives of this resolution. The proposed committee bill would create Section 205.194, Florida Statutes, which stipulates that a local occupational license may not be granted without proof and presentation of a state license. The FMA will monitor this provision throughout the Legislative Session to assure that it is maintained as a requirement in the Health Care and Insurance Committee's proposal and other proposals as necessary.

The Speaker called the membership of Palm Beach County to escort Dr. Elizabeth Joan Barice to the podium to be presented with the Certificate of Merit as commendation for exceptional and outstanding service to the Association, to the medical profession, and to the public in accordance with the Principles of Medical Ethics.

Certificate of Merit

Elizabeth Joan Barice, M.D.

Whereas, Elizabeth Joan Barice, M.D., of Singer Island, Florida, has rendered exceptional service to the Florida Medical Association, to organized medicine and to the public; and

Whereas, This dedicated physician was born in Camden, New Jersey, on January 10, 1941, attended the University of Florida and University of Florida College of Medicine and was graduated from Stanford University College of Medicine with a Doctor of Medicine and from Harvard University School of Public Health with a Master of Public Health degree; and

Whereas, This eminent lady served her patients with devotion in Internal Medicine for many years in the area of public health and has continued to serve the public in many activities which have focused on public health issues; and

Whereas, Dr. Barice has spent nine years of her career in research projects in an effort to improve the quality and value of health care by researching such areas as pharmacology and kinetics; and

Whereas, This dedicated individual is a participant in civic affairs having served as a member of the Drug Abuse Committee and The Charles Chairello Kidney Foundation in New Jersey, on the Board of Directors of both the Comprehensive Alcohol Rehabilitation Program and Project Outbound in West Palm Beach and on various committees by appointment; and

Whereas, Dr. Barice was a Delegate to the Florida Medical Association and served on the Medical Advisory Committee to United States Representatives; and

Whereas, She has been seen and heard by a television audience of millions as she spoke out on the subject of health, alcoholism and drug addiction and has published a book entitled, *The Palm Beach Diet*; and

Dr. E. Joan Barice accepts the Certificate of Merit from House Speaker, Dr. James B. Perry.

Whereas, This able individual continues to serve her profession by serving on the Executive Committee of the Palm Beach County Medical Society and as an Advisory to the Crippled Children's Society; and

Whereas, Dr. Barice has given freely of her time and talents to the medical community and to the people of the state of Florida and the world, therefore be it

RESOLVED, That a certificate of Merit be presented to Elizabeth Joan Barice, M.D., as a token of the warm regard and respect that the officers, members and executive staff of the Florida Medical Association hold for the many years of outstanding service rendered by this exceptional lady.

RESOLUTION 85-1
Public Relations Programs
Duval County Medical Society

RESOLUTION 85-10
Educational Advertising Campaigns
Dade County Medical Association

The motion of the Reference Committee that Resolutions 85-1 and 85-10 be considered together and referred to the Board of Governors carried.

RESOLUTION 85-1

Public Relations Program

(Referred to Board of Governors)

Whereas, Surveys have shown that the image of organized medicine in the eyes of the general public is less than desirable; and

Whereas, The traditional patient-personal physician relationship is being eroded by the movement towards alternative health delivery systems; and

Whereas, The Reason '84 effort awakened public awareness of the physicians' plight because of PLI; and

Whereas, The Florida Medical Association has not implemented an effective organized long-range program of public relations and positive physician image building; therefore be it

RESOLVED, That the FMA immediately develop a long-range program of public relations and positive physician image building, which is adequately funded and professionally staffed; and be it further

RESOLVED, That each county medical society be encouraged to establish a local public relations committee; and be it further

RESOLVED, That said long-range program of public relations be established in coordination with local county medical societies in order to maximize available talent and resources.

RESOLUTION 85-10

Educational Advertising Campaigns

(Referred to Board of Governors)

Whereas, The vast majority of the FMA membership endorses the private practice of medicine; and

Whereas, The membership is fearful of the greatest health care delivery system in the world being torn apart; and

Whereas, This organization should be dedicated in its fight to protect the private practice of medicine; therefore be it

RESOLVED, That the FMA immediately implement a statewide educational advertising campaign promoting the private practice of medicine and that this campaign continue until the 1986 Annual Meeting; and be it further

RESOLVED, That if additional funds are needed, each member be assessed a fair and appropriate amount, or the Association dues structure be amended to allow for this campaign.

RESOLUTION 85-3
Ruth Balle Recognition
Broward County Medical Society

Resolution 85-3 was adopted.

RESOLUTION 85-3

Ruth Balle Recognition

Brevard County Medical Society

RESOLVED, That the Florida Medical Association pay an official tribute to this outstanding lady of medicine, Ruth Balle, who has served our profession with dignity, pride, ability, and tender loving care; and be it further

RESOLVED, That a copy of this resolution be delivered to Ruth, in the form of a certificate, and a copy be rendered to the Brevard County Medical Society office and it members.

RESOLUTION 85-7
Relocation of FMA Headquarters
Dade County Medical Association

The motion from the Floor that Resolution 85-7 be referred to the Board of Governors carried.

RESOLUTION 85-7

Relocation of FMA Headquarters

(Referred to Board of Governors)

Whereas, The FMA member population base continues to shift southward; and

Whereas, Travel to Jacksonville from the state's population centers is extremely difficult; and

Whereas, Nearly all committee and council meetings are now held in locations other than the staff headquarters in Jacksonville; therefore be it

RESOLVED, That a committee composed of equal representation from each FMA district be created to conduct a feasibility study regarding the relocation of the Association headquarters to a more accessible location; and be it further

RESOLVED, That said report be presented to the 1986 Meeting of the House of Delegates.

RESOLUTION 85-13
Committee on Membership and Discipline
Broward County Medical Association

Resolution 85-13 was not adopted.

RESOLUTION 85-14
Florida Physicians Association
Broward County Medical Association

The motion from the Reference Committee that Resolution 85-14 be referred to the Board of Governors carried.

RESOLUTION 85-14

Florida Physicians Association

(Referred to Board of Governors)

Whereas, The Florida Physicians Association was created by the House of Delegates, while they report to the Board of Governors, the only activity reported to date has been of funds collected and dispensed; and

Whereas, The initial intent was to advise of third party contracts, possible trade union activity, carrier intervention as well as governmental; and

Whereas, The Florida Physicians Association apparently has adequate funds to conduct workshops, apply to the National Labor Relations Board for recognition as bargaining agent for Florida physicians, and other related activity; therefore be it

RESOLVED, That the FMA Board of Governors request the Florida Physicians Association to initiate positive programs supporting the intent of the House of Delegates at the time of generation of the Florida Physicians Association.

Vice Speaker Dr. Guy T. Selander of Jacksonville addresses the House of Delegates.

RESOLUTION 85-15
Specialty Society Awards
Lee County Medical Society

Resolution 85-15 was adopted.

RESOLVED, That no specialty society awards or recognition may be presented at a meeting of the FMA House of Delegates.

RESOLUTION 85-21
Non-Payment of 1984 Assessment
Dade County Medical Association

Resolution 85-21 was adopted.

RESOLUTION 85-21
Non-Payment of 1984 Assessment

RESOLVED, That the Board of Governors be instructed that no members be dropped from the Florida Medical Association and its component medical societies for non-payment of the 1984 mandatory assessment for professional liability until January 1, 1986.

The Chairman thanked each member of her Reference Committee: James T. Cook III, M.D., John C. Moore, M.D., Virgil A. Ponzoli Jr., M.D., Robert H. Hux, M.D., Glenn S. Hooper, M.D., and the AMA Delegate Advisors: T. Byron Thames, M.D. and O. William Davenport, M.D.; Mr. Donald C. Jones, Executive Director; Mr. John E. Thrasher, General Counsel; Ms. Linda Flowers, Recorder; and FMA staff members for their support of the Committee and the many members of the Association who attended their meeting and presented testimony.

The motion of the Reference Committee that the report of Reference Committee No. III, Finance and Administration, be adopted as amended carried.

The Council on Scientific Activities and leadership from Florida's Colleges of Medicine meet annually at the Dean's Luncheon. Left to right: Pierre J. Bouis Jr., M.D., Chairman, Council on Scientific Activities; Orris O. Rollie, M.D., Chairman, Committee on Medical Education; R. G. Lacsamana, M.D., newly appointed Editor of *The Journal of the Florida Medical Association, Inc.;* Robert C. Fore, Ed.D., Associate Executive Director for Programs; Daniel B. Nunn, M.D., Editor of *The Journal of the Florida Medical Association, Inc.;* Bernard J. Fogel, M.D., Dean, University of Miami School of Medicine; Frank C. Coleman, M.D., President, Florida Medical Association; Andor I. Szentivanyi, M.D., Dean, University of South Florida College of Medicine; Luis M. Perez, M.D., President-Elect, Florida Medical Association; Louis C. Murray, M.D., Chairman, Council on Legislation; William B. Deal, M.D., Dean, University of Florida College of Medicine.

The Vice Speaker, Dr. Selander, opened the floor for nominations of officers and AMA Delegates and Alternates.

Speaker of the House
Vice President
Secretary
Treasurer
AMA Delegate Seat #1
AMA Alternate Seat #4
AMA Delegate Seat #6
AMA Alternate Seat #6
AMA Delegate Seat #7
AMA Delegate Seat #8
AMA Alternate Seat #8

The Vice Speaker received a motion from the floor to elect by acclamation candidates for Vice President, Secretary, Treasurer, Speaker of the House, AMA Delegate Seats 1, 6, 7, 8 and Alternate Seats 4, 6 and 8, all of whom are incumbents and unopposed. The motion carried unanimously and the following candidates were elected.

Speaker of the House — Guy T. Selander, M.D.
Vice President — James G. White, M.D.
Secretary — Henry M. Yonge, M.D.
Treasurer — Yank D. Coble Jr., M.D.
AMA Delegate Seat #1 — T. Byron Thames, M.D.
AMA Alternate Seat #4 — Eugene G. Peek Jr., M.D.
AMA Delegate Seat #6 — Charles J. Kahn, M.D.
AMA Alternate Seat #6 — O. William Davenport, M.D.
AMA Delegate Seat #7 — Joseph C. Von Thron, M.D.
AMA Delegate Seat #8 — Louis C. Murray, M.D.
AMA Alternate Seat #8 — J. Lee Dockery, M.D.

The new terms for Delegate Seats 1, 6, 7, 8 and Alternate Seats 4, 6 and 8 are for two years (January 1, 1986 to December 31, 1987).

Nominations

President-Elect

The Vice Speaker opened the floor for nominations for the office of President-Elect. Dr. George P. Mesenger of Broward County nominated Dr. James B. Perry of Broward County. The nomination was seconded by Dr. Harold G. Norman of Dade County; Dr. Luis R. Guerrero of Palm Beach County; and Arnold L. Tanis of Broward County.

Speaker of the House

The floor was opened for nominations for the office of Speaker of the House. Duval County Medical Society nominated Dr. Guy T. Selander. The nomination was seconded by Dr. Rufus K. Broadaway of Dade County; Dr. Hector R. Mendez of Orange County; Dr. Paul A. Flaten of Broward County; Dr. Donald G. Nikolaus of Pinellas; Dr. William J. Romanos of Palm Beach County; Dr. Kenneth C. Kiehl of Sarasota County; Dr. Joseph E. Holland of Lake County; and the Seminole County Medical Society.

Vice Speaker

The floor was opened for nominations for the office of Vice Speaker. Dr. Ernest G. Sayfie of Broward County nominated Dr. Arthur L. Eberly of Broward County. The nomination was seconded by Dr. Charles A. Dunn of Dade County; Dr. Clyde M. Collins of Duval County; Dr. John N. Carlson of Sarasota County; Dr. Charles J. Kahn of Escambia County; Dr. Kay K. Hanley of Pinellas County; and Dr. Louis C. Murray of Orange County.

Dr. William J. Romanos Jr., of Palm Beach County nominated Dr. V.A. Marks for the office of Vice Speaker. The nomination was seconded by Dr. Virgil A. Ponzoli Jr., of Collier County; Dr. Howard W. Pettingill of Brevard County; Dr. Nanjunda Swamy of Columbia County; Dr. Fred S. Carter of Martin County; and Dr. David R. Arrowsmith of Okaloosa County.

Dr. James W. Walker announced that he withdrew his name as a candidate for AMA Alternate Seat #7.

AMA Alternate Seat #1

The Vice Speaker opened the nominations for AMA Alternate Seat #1. Dr. V.A. Marks of Palm Beach County nominated Dr. Daniel L. Seckinger of Dade County.

AMA Delegate Seat #4

Dr. Glenn S. Hooper of Hillsborough County nominated Dr. Frank C. Coleman of Hillsborough County. The nomination was seconded by Dr. Joseph H. Davis of Dade County and Dr. Ernest G. Sayfie of Broward County.

AMA Alternate Seat #3

Dr. William J. Romanos Jr., of Palm Beach County nominated Dr. Lee A. Fischer of Palm Beach County. The nomination was seconded by Dr. A. Fredrick Schild of Dade County and Dr. George T. Edwards of Broward County.

AMA Alternate Seat #7

Dr. Harold G. Norman nominated Dr. Charles A. Dunn of Dade County. The nomination was seconded by Luis R. Guerrero of Palm Beach County; Kenneth C. Kiehl of Sarasota County; and George T. Edwards of Broward County.

AMA Alternate Seat #9

Dr. Robert L. Dawson of Pinellas County nominated Dr. Kay K. Hanley of Pinellas County. The nomination was seconded by Dr. Ernest G. Sayfie of Broward County and Dr. A. Fredrick Schild of Dade County.

Judicial Council

The Speaker referred the House to the Report of the Board of Governors (Report F) in which the Board had nominated O. Frank Agee, M.D., of Gainesville to a five-year term expiring in 1990, on the Judicial Council as a representative from District A.

Committee on Membership and Discipline

The Speaker referred the House to the nominations for election to the Committee on Membership and Discipline as submitted by the Board of Governors in its supplemental Report F of the Board of Governors and advised the House that he would entertain any addtional nominations from the floor. The Speaker thereupon announced the names of the nominees for each district:

District 1:	Rufus Thames, M.D. (89)
District 2:	Herbert E. Brooks, M.D. (89)
District 3:	Joe C. Ebbinghouse, M.D. (89)
District 4:	Bruce R. Witten, M.D. (89)
District 5:	James E. Quinn, M.D. (89)
District 6:	Randall Jenkins, M.D. (89)
District 7:	Jeff W. Harris, M.D. (89)
District 8:	Royce Hobby, M.D. (89)
District 9:	Bettie R. Drake, M.D. (89)
District 10:	James D. Morgan, M.D. (89)
District 11:	E.J. Vann, M.D. (89)
District 12:	Reginald J. Stambaugh, M.D. (89)
District 13:	Martin F. Mihm, M.D. (89)
District 14:	James F. Smith, M.D. (89)
District 15:	Robert J. Brennan, M.D. (89)
District 16:	Jose F. Landa, M.D. (89)
District 17:	Maurice H. Laszlo, M.D. (89)
District 18:	Richard M. Fleming, M.D. (89)
District 19:	Linda A. Marraccini, M.D. (89)

The Speaker then announced that balloting would commence at 7:00 a.m. on Sunday prior to the opening session of the Third House of Delegates.

The meeting of the Second House of Delegates recessed at 5:45 p.m. to reconvene on Sunday, May 5, 1985, at 9:00 a.m.

Auxiliary Highlights

(1) Mrs. Milton (Jo) Tignor, President-Elect, and Mrs. V. A. (Susan) Marks, First Vice President (2) Displaying the Medi-File Card are Mrs. Barbara Castelli, Mrs. Bea George, and Mrs. Anne Swing (3) Mrs. Nancy Corwin (4) FMA-A President Mrs. Laurin G. (Nancy) Smith and President-Elect Mrs. Milton (Jo) Tignor (5) Dr. and Mrs. Milton Tignor (6) Dr. and Mrs. Laurin G. Smith (7) Dr. and Mrs. Laurin G. Smith and Dr. and Mrs. Milton F. Tignor

(8) Mrs. Nancy Smith and Mrs. Priscilla Gerber (9) Mrs. Marion Gilliland received the Auxiliary's Peggy Wilcox Award presented by Mrs. Edie Epstein (1) Mr. Douglas Kiker, FLAMPAC Speaker (11) Mrs. Nancy Smith presented Mrs. Jo Tignor with the FMA-A President's Pin (12) Mrs. Jo Tignor addresses the Auxiliary House of Delegates as the newly installed 85-86 FMA-A President (13) Mr. Douglas Kiker and Mrs. Jo Tignor at the Annual FLAMPAC Luncheon (14) FMA President-Elect Dr. Luis M. Perez and FMA-A President-Elect Mrs. Jo Tignor.

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Third House of Delegates

The third meeting of the House of Delegates convened at 9:10 a.m. on Sunday, May 5, 1985, Regency East/South Room of the Diplomat Hotel, Hollywood, Florida, James B. Perry, M.D., Speaker of the House presiding.

Dr. Richard I. Barr of the Credentials Committee reported that 193 delegates were registered, representing 36 county societies, which constitutes a quorum, and moved that the delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; Robert K. Casey, M.D.; Elayne E. Cassisi, M.D.; Richard M. Fry, M.D.; William T. Hawkins, M.D.; Gerold L. Schiebler, M.D.; Michael Fagien, Student Delegate.

BAY — James T. Cook III, M.D.; (Absent — B. Phillip Cotton, M.D.; Terrence R. Steiner, M.D.)

BRADFORD — (Absent — Carlos M. Hernandez, M.D.)

BREVARD — John B. Adamson, M.D.; Raymond A. Armstrong, M.D.; Richard I. Barr, M.D.; Antonio Catasus, M.D.; Howard W. Pettengill, M.D.; Robert C. Ufferman, M.D.; (Absent — Onofre P. Carrillo, M.D.)

BROWARD — Walter A. Campbell, M.D.; Andre S. Capi, M.D.; Phillip A. Caruso, M.D.; Thomas E. Corley, M.D.; David A. D'Alessandro, M.D.; George T. Edwards, M.D.; Ira Finegold, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; Theodore W. Hahn, M.D.; William C. Hartley, M.D.; Wayne R. Johnson, M.D.; George P. Messenger, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Ray E. Murphy Jr., M.D.; Ernest G. Sayfie, M.D.; Marvin L. Stein, M.D.; Arnold L. Tanis, M.D.; H. Murray Todd, M.D.; Alan J. Yesner, M.D.; (Absent — George J. Crane, M.D.; Arthur L. Eberly, M.D.; John M. Harper, M.D.; David C. Lane, M.D.; Joseph M. Sachs, M.D.; Richard D. Shafron, M.D.; Donald D. Sheffel, M.D.; Juan S.A. Wester, M.D.)

CAPITAL — Robert P. Johnson, M.D.; George N. Lewis, M.D.; Terence P. McCoy, M.D.; Robert N. Webster, M.D.; (Absent — Jack W. MacDonald, M.D.)

CHARLOTTE — Thomas R. Civitella, M.D.; Joseph R. Goggin, M.D.; Luis H. Serentill, M.D.

CITRUS — W. Randall Jenkins, M.D.; Samuel R. Miller, M.D.

CLAY — Clarence M. Harris, M.D.

COLLIER — Charles S. Eytel, M.D.; Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.

COLUMBIA — Nanjunda Swamy, M.D.

DADE — Jerome Benson, M.D.; Robert E. Boyett, M.D.; James W. Bridges, M.D.; Rufus K. Broadaway, M.D.; John O. Brown, M.D.; William P. Calvert, M.D.; Harlan S. Chiron, M.D.; Richard C. Clay, M.D.; Vincent P. Corso, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Norman T. Ditchek, M.D.; Charles A. Dunn, M.D.; Miguel Figueroa, M.D.; Denio O. Fonseca, M.D.; Simon Frank, M.D.; Antonio F. Frexes, M.D.; Richard L. Glatzer, M.D.; Joseph Harris, M.D.; Donald E. Johnson, M.D.; Maurice H. Laszlo, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Linda Marraccini, M.D.; Miguel A. Mora, M.D.; Dolores A. Morgan, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Manuel A. Porto-Sastre, M.D.; Pedro A. Ramos, M.D.; Jeffrey B. Raskin, M.D.; Harry T. Remmer, M.D.; A. Fredrick Schild, M.D.; Daniel L. Seckinger, M.D.; Everett Shocket, M.D.; Margaret C.S. Skinner, M.D.; Douglas Slavin, M.D.; Charles F. Tate, M.D.; Osvaldo D. Valdes, M.D.; Harold H. Weiner, M.D.; Steven M. Weissberg, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; (Absent — Manuel Abella-Fernandez, M.D.; Edward R. Annis, M.D.; Virgilio I. Beato, M.D.; Pedro P. Bosch, M.D.; N. Ralph Frankel, M.D.; Sean M. Kaufman, M.D.; Horace A. Leyva, M.D.; Charles A. Monnin Jr., M.D.; Oscar Sandoval, M.D.; Marvin B. Slotkin, M.D.; Samuel P. Stokley, M.D.; Claudio R. Villoch, M.D.; Ana Isabel Gonzalez, Student Delegate)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Clyde M. Collins, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Walter A. Harmon, M.D.; Charles P. Hayes Jr., M.D.; Benjamin A. Johnson, M.D.; John F. Lovejoy, M.D.; Charles B. McIntosh, M.D.; Charles T. Montgomery, M.D.; Kurt W. Mori, M.D.; John A. Rush, M.D.: Jack L. Sapolsky, M.D.; Seabury D. Stoneburner Jr., M.D.; Robert H. Threlkel, M.D.; George S. Trotter, M.D.; James W. Walker, M.D.; H. Warner Webb, M.D.; (Absent — Gaston J. Acosta-Rua, M.D.; William P. Booras, M.D.; Leif A. Lohrbauer, M.D.; Daniel B. Nunn, M.D.)

ESCAMBIA — Richard H. Ciordia, M.D.; Eric F. Geiger, M.D.; Charles J. Kahn, M.D.; Michael R. Redmond, M.D.; Robert K. Wilson Jr., M.D.; Henry M. Yonge, M.D.; (Absent — C. Fenner McConnell, M.D.)

FLAGLER — (Absent — John M. Canakaris, M.D.)

FRANKLIN-GULF — (Absent — Joseph P. Hendrix, M.D.)

HERNANDO — Clinton J. McGrew Jr., M.D.

HIGHLANDS — Joseph A. Mitchell, M.D.; Luis M. Pena, M.D.

HILLSBOROUGH — Richard A. Bagby, M.D.; Frank C. Coleman, M.D.; Richard G. Connar, M.D.; Thomas H. Greiwe, M.D.; Richard S. Hodes, M.D.; Glenn S. Hooper, M.D.; Robert G. Isbell, M.D.; Victor H. Knight Jr., M.D.; Ralph E. Rydell, M.D.; Stewart Siddall, M.D.; Gerald L. Stoker, M.D.; Ferdinando Vizzi, M.D.; James A. Winslow Jr., M.D.; (Absent — Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Thomas E. McKell, M..; Ronald L. Seeley, M.D.; Harold L. Williamson, M.D.; T. Roland Reeves, Student Delegate)

INDIAN RIVER — Kip G. Kelso, M.D.; Michael B. Zimmer, M.D.; (Absent — Donald L. Ames, M.D.)

LAKE — Joseph A. Comfort, M.D.; Joseph E. Holland, M.D.; Robert H. Hux, M.D.

LEE — Larry P. Garrett, M.D.; H. Quillian Jones Jr., M.D.; Marcus M. Moore, M.D.; Douglas A. Newland, M.D.; Stephen R. Zellner, M.D.; (Absent — F. Lee Howington, M.D.)

MADISON — (Absent — Michael O. Stick, M.D.)

MANATEE — Thomas R. Busard, M.D.; Robert A. Fasoli, M.D.; Julian Giraldo, M.D.; Roger A. Meyer, M.D.; (Absent — William A. Boyce, M.D.)

MARION — Claude B. Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; Andrew F. Greene, M.D.; (Absent — George E. McLain, M.D.)

MONROE — Ronald H. Chase, M.D.

NASSAU — (Absent — Robert L. Taylor, M.D.)

OKALOOSA — David R. Arrowsmith, M.D.; William W. Thompson, M.D.

ORANGE — Richard J. Bagby, M.D.; Clifford D. Bidwell, M.D.; Manuel J. Coto, M.D.; Wayne L. Godbold, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; Wallace M. Philips Jr., M.D.; Philip N. Styne, M.D.; T. Byron Thames, M.D.; Cecil B. Wilson, M.D.; (Absent — Edward Ackerman, M.D.; Henry J. Baskin, M.D.; David L. Mackey, M.D.; Calvin R. Peters, M.D.; Robert N. Serros, M.D.)

OSCEOLA — John R. Hartman, M.D.; Alonzo J. Logan, M.D.

PALM BEACH — Vernon B. Astler, M.D.; E. Joan Barice, M.D.; Richard C. Cavanagh, M.D.; McKinley Cheshire, M.D.; Ralph R. Eastridge, M.D.; Lee A. Fischer, M.D.; George L. Ford Jr., M.D.; J. Russell Forlaw, M.D.; Luis R. Guerrero, M.D.; James M. Johnson, M.D.; V.A. Marks, M.D.; Gilbert R. Panzer, M.D.; William J. Romanos Jr., M.D.; Joel F. Smith, M.D.; Milton R. Tignor Jr., M.D.; Dick L. Van Eldik, M.D.; (Absent — Robert Burger, M.D.; Ben R. Thebaut Jr., M.D.)

PANHANDLE — Herbert E. Brooks, M.D.

PASCO — Vincent Cotroneo, M.D.; Carl W. Graves, M.D.; (Absent — Maynard F. Taylor, M.D.)

PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; Anthony Garritano, M.D.; William E. Hale, M.D.; Kay K. Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris LeVine, M.D.; Jack A. MaCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overby, M.D.; Bruce P. Smith, M.D.; (Absent — Howard L. Reese, M.D.; William H. Schmid, M.D.; Walter H. Winchester, M.D.)

POLK — Ronald W. Case, M.D.; Richard Garcia, M.D.; John W. Glotfelty, M.D.; William F. Hill, M.D.; David T. Jones, M.D.; John C. Moore, M.D.; Robert B. Peddy, M.D.; Daniel W. Welch, M.D.

PUTNAM — Edward D. Risch, M.D.

ST. LUCIE-OKEECHOBEE — Khalil A. Cassimally, M.D.; (Absent — David L. Fromang, M.D.; Manuel G. Garcia, M.D.)

SANTA ROSA — David B. Young, M.D.

SARASOTA — Jack E. Baron, M.D.; Richard J. Beebe, M.D.; John N. Carlson, M.D.; Robert W. Dein, M.D.; Kenneth C. Kiehl, M.D.; Franklin H. Pfeiffenberger, M.D.; Richard C. Rehmeyer, M.D.; Ernest C. Smith Jr., M.D.; David L. Thomas, M.D.

SEMINOLE — Humberto A. Dominguez, M.D.; Orlando Garcia-Piedra, M.D.; Maria P. Perez, M.D.

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Philip L. Carey, M.D.)

TAYLOR — (Absent — John H. Parker, M.D.)

VOLUSIA — Harry F. Farmer, M.D.; Remigio G. Lacsamana, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.; Charles A. Stump, M.D.; (Absent — Martin S. Feigenbaum, M.D.)

WALTON — (Absent — James D. Lawlor, M.D.)

WASHINGTON — (Absent — Muhammad I. Zafar, M.D.)

SPEAKER OF HOUSE — James B. Perry, M.D.

VICE SPEAKER — Guy T. Selander, M.D.

COUNCIL ON HOSPITAL MEDICAL STAFFS — Raymond F. Barnes, M.D.

Dr. Perry then recognized President, Dr. Frank C. Coleman, and asked that he come forward to install the new President.

Dr. Coleman presented the personal gavel and the President's Plaque to Dr. Luis M. Perez, the new President of the Florida Medical Association, Inc.

Dr. Perez in turn presented Dr. Coleman with the Past President's Pin, the new Past President's green blazer and gold cufflinks which have the same emblem as the Past President's Pin.

Dr. Perez then asked Mrs. Coleman, escorted by Dr. Glenn S. Hooper and Dr. Robert G. Isbell, to come to the platform for presentation of Dr. Coleman's portrait.

Remarks — Luis M. Perez, M.D., President

In the life of every person there are events that produce a change of direction, and even though it may not be known at that moment, these events may change one's life.

In my life in particular, the events that directed my destiny are these: graduation from medical school; marriage a year later, and then moving to a foreign country with a new language and a different philosophy and psychology; the birth of my sons; the take over of my native country by a communist regime, making impossible my return; passing the basic sciences and the Board of Medical Examiners; the start of private practice; suffering a myocardial infarction and coding three times; being elected by the House of Delegates first as Alternate Delegate then Delegate to the AMA; being elected Secretary of the FMA and finally, last year, President-Elect.

Now, taking office as your President is the culmination of a dream and, I know, a new direction to my life.

I think that, subconsciously, I have been preparing myself for this all these years, but I assure you that this past year as President-Elect, following Dr. Coleman to meeting after meeting, has proven to be more intense and demanding than my Internship and Residency years put together.

I never had to work so hard as I did to keep up with someone as dynamic as this man, with his strong personality, and his never ending capacity for work. It has been a rewarding experience and I can only hope that I will give my President-Elect such an example.

I want to mention to you at this time those who truly have the burden of facing the biggest sacrifices; they will have to be very patient with me:

First my wife, always at my side and my best sounding board, who always has and always will put up with endless days and nights of solitude and anxiety during my travels to distant places, in inclement weather, in small airplanes — Dr. Maria Perez;

My children, who also suffered the absence of their father while I was pursuing our aims for the good of all physicians in Florida — Luis Martin Perez Jr., and Hector "Tico" Perez;

My associate, who for the last year has been holding our practice together while I was away and will continue to do so — Dr. Chester D. Miltenberger;

And the staff in my office, with whom you are going to talk over the telephone for the next 16 months — Mrs. Ann Brady, Mrs. Nat Bentley, and Mrs. Judy Walker.

I also want to recognize the doctors in Sanford and Seminole County Medical Society, who over all these years have encouraged me to pursue my desires, and have helped me by their understanding and by facilitating coverage all the times I have been out of town on FMA business.

Last year was a difficult year for the FMA. This year, I know very well, is not going to be a rose garden. It is going to require a constant effort from the ones who represent you at the local, state and national level, because the surmounting difficulties that lie ahead for the practice of medicine in general are many and uncertain.

At the state level, the professional liability insurance issue continues at the front burner with several bills and modifications of the PLI package already introduced. We are watching very closely every one of the moves in this direction. Some are only window dressings; we will expose them as such. Others are more radical and may even be productive. We will support them as intensely as possible.

We are not considering these bills from the emotional point of view. Every one of them is analyzed by our consultants, actuarians and attorneys to determine which ones are the really useful, to diminish the incidence of frivolous suits and reduce the insurance premiums and awards.

Accidents happen in medicine and errors are committed like in any other human activity, and those patients who have to live with the result of accidents or errors should be fairly compensated, but there has to be a method by which the maloccurrence in medical treatment can be separated from the errors and preventable accidents.

The issue of non-physicians providers, which keeps rising its ugly head, year after year, threatening the quality of medical care to the public of our state, and increasing the liability issue to the physicians in hospital staffs, the physicians that oversee these individuals and the hospitals themselves.

Some sense has to be brought to the Legislators who eventually have to realize how detrimental this deviation from quality in the practice of medicine can be to the people of the state.

The drug abuse problem in our youngsters and middle age population continues to be an increasing problem in our society with its logical consequences in health care for these individuals. We should address this problem and offer guidance and education.

The young physicians, fresh out of their residency, face a serious problem. Pressed by debts from Medical School and training years, come into a new environment with very little guidance in how to manage. They have to face offers by entrepreneurs who run a gamut of health services which are very tempting as a fast solution and without having the insight of what it means to their future, and they are lured into these types of organizations. We have to give guidance and orientation to the young physicians if we want to preserve the individuality and independence of the medical practice and we have decided we will do so.

The increasing problems of quality of care at HMOs, IPAs, PPOs, etc. and the overutilization and exploitation of the health insurance companies benefits and abuse to patients at some ambulatory clinics, the so-called emergency or surgical medical centers and a few individual practitioners who have to be controlled in some manner. The Florida Medical Association has a moral and ethical duty to find the way to do so.

At the national level, the spectrum of DRGs for physicians in hospital practices, with all the complications this is bound to bring, the freezes on Medicare with increases in deductibles that penalizes not only hospitals and physicians, but the elderly population which is forever increasing in our state. The cuts in educational and research funds with a terrible implication for the future physicians and the health of the nation in the long run. The emphasis of the federal government on economy, divorced from quality of care, with its logical consequences, will bring about patient suffering and increases in liability. These are but a few, certainly not all of the issues we will be facing.

What are we to do next? In which direction shall we go to curtail, or at least ameliorate this trend? What kind of guidance must we offer the physicians in Florida and to the public in general whose health and wellbeing is our outmost responsibility?

First, we are going to continue our efforts this year in the Legislation to affect the necessary changes in order to diminish the PLI problems and the situation with non-physician providers. At the same time we are going to start an agressive public education program guided by professional public relation individuals to enhance the image of the physician and the benefits of the private practice of medicine, emphasizing the quality of care and all the attempts to diminish it for purely unfounded economical reasons.

We are also going to continue building bridges and liason with other groups vitally interested in PLI and quality of care at an affordable price, to form a solid front with clear understanding of the direction we are going, since there is a possibility in 1986 that we will have to appeal again to the public with another Constitutional Amendment on the PLI issue.

At the national level, our delegation, more and more influential as we grow larger, and more experienced under the leadership of Dr. Charles Donegan and the National Legislative Committee of our Association with Dr. Louis Murray as Chairman, will coordinate with AMA efforts in emphasizing our views and how these policies affect our state and the nation in general.

The work ahead is not going to be easy.

The Executive Committee of your Association and the members of the Board will have the responsibility to keep the link of communications open with the local medical societies in their district, and with medical staffs in hospitals from the area they represent.

And I appeal to you all, the Delegates from our component medical societies, to keep abreast of the issues and utilize every staff meeting, specialty meeting and medical society meeting you attend to keep everyone informed of our activities and efforts.

There have been serious problems with communication in the past, not because we have not tried to communicate. You and I have had innumerable Presidential Memos last year, which kept us informed of each and every problem. In every issue of *The Journal*, the President's Message and news of all the activities of the Association, has been published, and still, when we visited several local medical societies, we have had to answer questions on basic issues clearly stated over and over again, because the average physician does not take a few minutes to read our communications.

This will be one of our principal goals. We have to educate our members to realize that this Association and the AMA are vital to their professional careers, and even though the practice of medicine will never be as it was ten years ago, we, and only we, can influence the direction in which it is going to go.

Recognizing this, we have to develop a tighter society, a unity of direction, a better knowledge of the issues and the political realities of our times. We must be ready to be counted, to offer imaginative and novel solutions to the problems that face us, altering, modifying, changing concepts in the minds of the public at large, and exposing the proposals of our adversaries who are working diligently at the Federal level with the purpose of creating a socialistic type of medical services throughout the nation. We must show those who try to maintain chaos and confusion among ourselves, that they cannot reap, in the courts of law, the benefits that create their wealth, at our expense and that of our patients. This is why the theme for this year is going to **Unity.**

We have to regroup, to take the offensive. For too many years we have been coping with problems as they have been presented

Luis M. Perez, M.D., FMA President-Elect, addresses the House of Delegates.

to us and we have been at the defensive, but later we have learned, we have observed the process, we have analyzed, one by one, our defeats, and we have learned. We have dissected layer by layer each one of the processes we have been entangled with, and we have learned, and will continue learning.

And now we know our weaknesses and our strengths. And now we know that if we close the ranks, if we produce the necessary Unity for our efforts to culminate, if we take the offensive instead of the defensive position, our efforts will fructify and our profession will remain one of honor and distinction, respected and admired by all, for the benefit of the health of the people of our state and an example to the Nation.

I hope that my ideas and strengths are added to and built upon daily by this confidence and a continued input with constructive criticism from each and every one of you — our Delegates and medicine's leaders.

I would like to acknowledge my wife, Peg, and our six adult offspring and friends who have put up with my time-consuming interest in FMA activities. They have been an inspiration and a source of strength which I continue to draw upon daily.

I have a great deal of appreciation for the Broward County Medical Association and its delegation without whose continuing support, advice and efforts I would not be standing here today. I know that their leadership and hope their entire membership became an integral part of this Association's goal of 100% participation in the Florida Medical Association and its FLAMPAC organization.

I also give honor, respect and a deep feeling of thanks to my partners Willis Dickens, Roger Schnell, Gerold Golberg, Harrish Thaker and Linda Brown. Their support, coverage and help have been outstanding and without restraint.

As a member of the Board and a listener to the problems of various county societies, I have come to realize that a multifaceted approach to our many problems is not only necessary but is vital to our survival and to our ability to represent fellow colleagues in the arena of existence in which we find ourselves today.

I see challenges in the future of medicine that will make the last few years' problems picayune by comparison. These will have to be tackled on a day-to-day basis and with the input of each and every member of this Association. Solutions will be forthcoming and seemingly insurmountable obstacles need to be overcome.

I have enjoyed working with our President and Board who have become close, personal friends. This friendship is honed in the attrition of battle by fights both won and lost in your behalf. I personally thank each and every one of you for your efforts, insight and dedication that have allowed us to conclude another successful year and I call upon all to continue your support and help. I personally, and the Association collectively, need this effort. And I thank you all for your help and diligent sacrifices. God bless you and your families.

Election Results

At this time the Vice Speaker, Dr. Selander, advised the members of the House of Delegates of the results of elections held for the office of President-Elect.

President-Elect

The Vice Speaker announced that Dr. James B. Perry had been elected President-Elect.

Acceptance Speech of President-Elect

It us with a great sense of apprehension and humility that I accept the office of President-Elect — that you have in your generosity and out-pouring of confidence, encouragement and vote allowed me to attain.

Dr. James B. Perry makes his acceptance speech for the office of President-Elect.

Vice President
Secretary
Treasurer
AMA Delegate Seat #1
AMA Alternate Seat #1
AMA Alternate Seat #3
AMA Delegate Seat #4
AMA Alternate Seat #4
AMA Delegate Seat #6
AMA Alternate Seat #6
AMA Delegate Seat #7
AMA Alternate Seat #7
AMA Delegate Seat #8
AMA Alternate Seat #8

Vice President — James G. White, M.D.
Secretary — Henry M. Yonge, M.D.
Treasurer — Yank D. Coble Jr., M.D.

AMA Delegate Seat #1 — T. Byron Thames, M.D.
AMA Alternate Seat #1 — Daniel Seckinger, M.D.
AMA Alternate Seat #3 — Lee Fischer, M.D.
AMA Delegate Seat #4 — Frank C. Coleman, M.D.
AMA Alternate Seat #4 — Eugene G. Peek Jr., M.D.
AMA Delegate Seat #6 — Charles J. Kahn, M.D.
AMA Alternate Seat #6 — O. William Davenport, M.D.
AMA Delegate Seat #7 — Joseph C. Von Thron, M.D.
AMA Alternate Seat #7 Charles Dunn, M.D.
AMA Delegate Seat #8 — Louis C. Murray, M.D.
AMA Alternate Seat #8 — J. Lee Dockery, M.D.
AMA Alternate Seat #9 — Kay K. Hanley, M.D.

The new terms for Delegate Seats 1, 4, 6, 7, and 8 and Alternate Seats 1, 3, 4, 6, 7 and 8 are for two year terms beginning January 1, 1986 and ending December 31, 1987. Alternate Seats 3 and 9 will complete the term expiring December 31, 1986.

The Speaker, Dr. Perry, advised the members of the House of Delegates of the results of elections held for the offices of Vice Speaker and Committee on Membership and Discipline Districts 6 and 11.

Vice Speaker

The Speaker announced that Dr. Arthur L. Eberly had been elected Vice Speaker. Dr. V.A. Marks congratulated Dr. Eberly and moved that the election be by unanimous consent of the House of Delegates. The motion carried.

Committee on Membership and Discipline

The Speaker announced the results of District 6 and 11.

District 1: Rufus Thames, M.D. (89)
District 2: Herbert E. Brooks, M.D. (89)
District 3: Joe C. Ebbinghouse, M.D. (89)
District 4: Bruce R. Witten, M.D. (89)
District 5: James E. Quinn, M.D. (89)
District 6: Randall Jenkins, M.D. (89)
District 7: Jeff W. Harris, M.D. (89)
District 8: Royce Hobby, M.D. (89)
District 9: Bettie R. Drake, M.D. (89)
District 10: James D. Morgan, M.D. (89)
District 11: E.J. Vann, M.D. (89)
District 12: Reginald J. Stambaugh, M.D. (89)
District 13: Martin F. Mihm, M.D. (89)
District 14: James F. Smith, M.D. (89)
District 15: Robert J. Brennan, M.D. (89)
District 16: Jose F. Landa, M.D. (89)
District 17: Maurice H. Laszlo, M.D. (89)
District 18: Richard M. Fleming, M.D. (89)
District 19: Linda A. Marraccini, M.D. (89)

Change of Command

One of the highlights of the Third Session of the House of Delegates was the installation of the new President Luis M. Perez, M.D., and recognition of the many contributions of Immediate Past President Frank C. Coleman, M.D. (1) Immediate Past President Frank C. Coleman, M.D., presents the President's Plaque to Luis M. Perez, M.D., the new President of the Florida Medical Association, Inc. (2) Frank C. Coleman, M.D., proudly receives the Past President's Coat and Pin from President Luis M. Perez (3) Outgoing President Coleman passes the gavel to President Perez (4) According to tradition, the large portrait of the President which has been hanging in the lobby of the FMA Headquarters Office for the past year is presented to the President's wife at the Annual Meeting. President Luis M. Perez, M.D., presents the portrait to Mrs. Frank C. (Ruth) Coleman.

Report of Reference Committee No. IV Legislation and Miscellaneous

Dr. Selander called the Chairman and members of Reference Committee IV, Legislation and Miscellaneous, to present their report.

Dr. Kenneth C. Kiehl, Chairman, and his Committee came forward to present the report of Reference Committee IV, Legislation and Miscellaneous.

The Committee expressed its desire to publicly commend Dr. Louis C. Murray for his outstanding work in his role as Chairman of the Council on Legislation. The Committee further recognized and commended Thomas P. Wood, M.D., Chairman of State Legislation; Mr. Donald S. Fraser Jr., Deputy Executive Director, Legislation and Public Affairs; Mr. George S. Palmer Jr., Assistant Director, Legislative Affairs; Mr. Jim McCloy, Assistant Director, Legislative Affairs; Mrs. Lucy Mohs, Legislative Analyst; and to all other FMA Staff members who provided outstanding support of our legislative program. The Committee also recognized the contributions of all members of the Florida Medical Association who participated in FMA legislative activities during the past year.

Council on Legislation

The Report of the Council on Legislation was filed.

Council on Legislation

Louis C. Murray, M.D., Chairman

Most of the work of the Council on Legislation is accomplished through activities of its two committees: the Committee on State Legislation and the Committee on National Legislation. The report of your Council is submitted as individual reports of the two major committees.

Committee on National Legislation

This Committee consists of the key contact physicians for each member of the Florida delegation of the U.S. Senate and the U.S. House of Representatives. Members of this Committee have kept in close touch with their assigned senators and congressmen on the national legislative matters of interest to the FMA and American Medical Association.

The Association has maintained active liaison with members of the Florida Congressional Delegation on key legislative issues. Conferences in Washington between FMA staff, key contact physicians and selected congressmen were necessary in order to carry out the FMA and AMA policies on these issues. In addition to these individual visits, a comprehensive program of visitations was conducted by FMA key contact physicians and officers with the two U.S. Senators and House members who served on committees with jurisdiction over key health issues. This continuing personal liaison resulted in excellent cooperation from Florida's delegation.

The issues that necessitated major action by the FMA and contact physicians were:

— Support for legislation to prohibit the FTC from using its authority to preempt state laws relative to professional licensure or tasks professionals may perform.
— Opposition to proposals that mandate physician acceptance of Medicare assignment.
— Opposition to legislation concerning governmental intervention in the care and treatment of newborns with life-threatening congenital impairments.
— Opposition to the legalization of heroin to use for pain if cannot be managed with currently available medications.
— Opposition to the extension of chiropractic and optometric services to military and veteran programs.

The Ninety-ninth Congress promises to be increasingly active in federal health legislation. Among the key issues that will be considered that are of particular interest to the FMA are:

— Opposition to the expansion of the use of prospective payment and D.R.G. system to specifically include physicians.
— Oppose efforts to impose further regulations on the practices of physicians in the hospital setting.
— Establishment of a Federal Vaccine Injury Compensation Program to compensate individuals who suffer certain injuries caused by designated injuries.
— Monitor efforts to modify malpractice laws at the federal legislative level.
— Changes in the federal financing of medical education.
— Amendments to the PRO law relating to confidentiality, sanctions, appeals and reconsiderations, and conduct of review.

This will require the Association to continue to maintain close liaison with Florida's Congressional Delegation and with the AMA Washington Office.

Committee on State Legislation

The Committee on State Legislation has had another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized specialty groups. Seven formal meetings of the Committee have been held, along with informal conferences among Committee members as items of an urgent nature arose.

Consistent with the policies developed by the FMA House of Delegates, the Committee has worked closely with the Board of Governors in developing our legislative program for the 1985 session of the Florida Legislature.

The following items summarize the Committee's activities:

1. The legislative program is continuing to function under the supervision of Donald S. Fraser, Jr., Deputy Executive Director, Legislation & Public Affairs. He has been materially assisted by Mrs. Lucy Mohs, Legislative Analyst, George S. Palmer, Jr., Assistant Director of Legislative Affairs, and Jim McCloy, Assistant Director of Legislative Affairs. Particularly helpful to the legislative activity have been the FMA Field Offices. These have greatly increased the Association's ability to maintain liaison with county medical societies, contact physicians and members of the Legislature.
2. The Capitol Dispensary. The Committee placed major emphasis on working with the Capitol Dispensary which has proven to be most important in meeting the needs of legislators and their staffs. Mrs. Linda Bass, R.N., head of the clinic, has continued to provide excellent assistance to the FMA in coordinating the activities of the Dispensary for the Doctor of the Day Program.
3. The Committee on State Legislation is continuing to emphasize the need to develop a good key contact physician program in each county medical society in the state. In addition, priority attention has been directed toward increasing the role of the Auxiliary in the Association's efforts.
4. Publications. A legislative bulletin was published every week during the legislative session and periodically between sessions. The bulletin is designed to give up-to-date information to members of the FMA who are involved in legislative activities. A listing of all bills monitored by the Capital Office is sent on a regular basis to county medical society executives and legislative chairmen. In addition, summaries and copies of key legislative proposals are distributed.
5. 1984 Legislative Accomplishments. During the 1984 Legislative session, there were more than 300 legislative proposals that required action by the Committee on State Legislation or the Capital Office staff. Matters of major interest to the Florida Medical Association were:

Issues Opposed by the Florida Medical Association Which were Defeated in the 1984 Legislative Session

— Authorization for establishment of Exclusive Provider Organizations (EPO's) in Florida.
— Statutory authorization for certain pharmacists to prescribe certain drugs from a formulary which is developed by a joint committee of the pharmacy and medical boards. Third party reimbursement would cover the prescription of such drugs and the pharmacy board would determine educational requirements, if any, to be able to become a "health-care consultant" (SB 45/HB 104).
— A requirement for hospitals to grant staff privileges to nurse anesthetists. Privileges cannot be denied only because a person is a nurse (SB 386/HB 620).
— Increased regulation of basic office personnel taking x-rays. The 1984 Legislature did adopt a licensure law containing no problem areas for primary care or other physicians (CS/SB 242).
— Reenactment of the licensure law for lay midwives. While the current licensure law was not reenacted, the Legislature did adopt a "grandfather" clause for those currently licensed or enrolled in midwifery schools (CS/SB 231).
— A requirement for blood banks and hospitals to allow a person to donate blood only for a specific relative (HB 241).
— Mandated hospital staff privileges for psychologists, lay midwives and nurse practitioners (SB 277, SB 407, HB 565, HB 418).
— Mandated certification and statutory delineation of duties of medical assistants (SB 97).
— Mandatory second surgical opinions (HB 894).
— Non-denial of hospital staff privileges for physicians tied to hospital occupancy rates (SB 460).
— Creating new definition of "medical" to include services rendered by chiropractors for purposes of the School Health Services Act (SB 272/HB 325).
— Establishment of "peer review committees" operating under the Department of Professional Regulation that would review and handle complaints about physicians' fees.
— Removal of exemption of confidentiality of medical staff meeting records from the Open Records Law (Proposed Committee Bill/Judiciary Committee).
— Requirement for insurance companies to institute programs to reward policyholders for the discovery of errors or overcharges on hospital bills. Insurors would be required to provide a monetary award not to exceed $1,000 for such a discovery (HB 179).

Reference Committee IV (Legislation and Miscellaneous) was chaired by Kenneth C. Kiehl, M.D., of Sarasota. Left to right: AMA Delegate, Sanford A. Mullen, M.D., Jacksonville; E. Joan Barice, M.D., Singer Island; David R. Arrowsmith, M.D., Ft. Walton Beach; Arnold L. Tanis, M.D., Hollywood; Kenneth C. Kiehl, M.D., Chairman, Sarasota; Louis C. Murray, M.D., AMA Delegate (Standing), Orlando; Mrs. Diane Bowker (not pictured), Recorder; Charles A. Dunn, M.D., Miami; Samuel L. Renfroe, M.D., Ocala; and Thomas R. Busard, M.D., Bradenton.

— Removal of the exemption from the Open Records Law of complaints against regulated professionals (HB 1269).
— Authorization for professional licensing boards to approve foreign medical schools; provide for remedial education; allow foreign medical graduates to be physician assistants (HB 1267).
—A requirement for medical examiners to obtain written consent from next of kin of deceased prior to removal or corneal tissue for a transplant (HB 394).

Other Health Legislation Passed by the Legislature

— Rewrite of the radiologic technologist law which allows basic x-ray machine operator to be utilized in all physician offices.
— Reenactment of the lay midwifery law which allows currently licensed lay midwives to continue their practice while subsequent midwives must be certified nurse midwives.
— Legislation that allows any competent adult to make a written declaration directing the withholding of life-prolonging procedures in the event such person has a terminal medical condition (CS/HB 127).
— Legislation expanding the coverage for newborn children in health insurance policies to include the newborn child of a family member of the insured or subscriber (SB 682, HB 260).
— Authorization for the Department of Professional Regulation to take disciplinary action against a provider who advertises a free service and then charges for it (SB 515, HB 837).
— Clarifying legislation that provides for separation of the regulation of health maintenance organizations and pre-paid health clinics ("Quintas") (SB 342).
— Authorization for the Department of HRS to set standards for the licensure of freestanding birth centers. Requires the centers to only accept patients who anticipate a normal delivery and further requires consultation agreements with physicians who have hospital obstetrical privileges (SB 782).
— Prohibition of sale of human body parts for valuable consideration, which does not include costs associated with removal, storage, or transportation (CS/SB 143).
— Abolishment of local mental health boards and restructuring of community mental health programs to include alcohol and drug abuse services (SB 797).
— Revision of the child abuse law including creation of child protection teams and recognition for guardians ad litem. Extensive injunctive powers are authorized to protect an abused child (CS/HB 988).
— A State Athletic Commission is created to regulate professional boxing (HB 171).
— Development of a brochure detailing breast cancer treatment alternatives by the Florida Cancer Control and Research Advisory Board. Communication of such information is required for certain patients by physicians (CS/HB 279).
— Authorization for the Department of Professional Regulation to take action to stop unlicensed professional activities (CS/SB 356).
— Authority is granted to physical therapists to perform assessments upon the request of persons who may prescribe such services (SB 546).
— Amendments were made to the Emergency Medical Services Act to clarify authority and various definitions (CS/SB 529).
— The School Health Services Act was substantially revised to clearly delineate responsibilities for implementation and standard setting (CS/SB 529).
— Regulates members of the Armed Forces who are engaged in their licensed profession in the private sector for profit to meet the licensure requirements, including the payment of fees (HB 1006).
— Makes it unlawful for a person to withhold information in order to obtain a controlled substance or a prescription for same from a practitioner when that person has received a similar substance within the last 30 days. In addition, the bill makes it unlawful to possess a prescription form not completed and signed by the practitioner whose name is imprinted on the form (CS/SB 228).
— Establishes state regulation of respiratory therapists through certification or registration pursuant to an examination (CS/HB 775).
— Reenacts the Occupational Therapy Licensure Act with an expanded disciplinary section (CS/SB 151).
— Amends the Pharmacy Practice Act to create an impaired pharmacists program (CS/SB 365).
— Establishes licensure requirements for persons performing electrolysis and creates an advisory council under the State Board of Medical Examiners (CS/SB 210).
— Amends Psychological Services Practice Act to require approval of continuing education for providers, programs and courses. A new section permits certain psychologists to practice hypnosis (HB 1013).
— Reenacts the Speech-Language Pathology and Audiology Act (SB 219).
— Gives the Department of HRS authority to interpret, by rule, the American College of Surgeons standards for trauma centers (CS/SB 529).
— Classifies aggravated child abuse as an element of murder in the first degree and second degree (SB 72).
— Provides for the definition of "private" swimming pool and exempts such from inspections by DHRS (CS/HB 262).
— Reenacts Chapter 404, F.S., which provides for the regulation of radiation producing machines and materials (CS/SB 241).
— Creates a legal obligation on employers to inform employees of the presence of any toxic substance found on the Florida Sunshine List in their place of work (CS/HB 426).
— Amends the Patient's Rights section of the Nursing Home Licensure Act to require nursing homes to reserve, for up to 15 days for a single hospitalization, a patient's bed when such patient is a Medicaid patient (CS/HB 255).
— Appropriates $3.9 million for the state to provide health insurance coverage to persons retired prior to January 1, 1976 under a state administrated retirement system and to surviving spouses not covered by Social Security (CS/SB 943).
— Changes the Patient's Compensation Fund fiscal year from July 1 - June 30 to January 1 - December 31 and delays increases in entry level amounts for six months to comply with fiscal year changes (HB 871).

Issues Vetoed by Governor Bob Graham

Governor Bob Graham exercised his veto authority by withholding approval of these bills and a portion of the 1985-86 budget that passed the 1984 Legislative Session.

Dental Anesthesia Amendment (CS/HB 997 and CS/SB 341) — Contained an amendment that would have allowed dentists to administer non-dental anesthesia.

Mandatory Chiropractic Insurance Coverage (HB 475) — Mandatory insurance coverage for chiropractic services.

Chiropractic College Appropriation — $150,000 from the General Revenue Fund to establish a school of chiropractic in the state.

Major Objectives of the FMA for the 1985 Session of the Legislature

— Support for solutions for resolving the professional liability crisis that will achieve stability in respect to the current cost of professional liability insurance and will provide to patients who are truly injured in the medical system an opportunity to

be adequately and efficiently compensated for their injuries and, further, that the FMA support the following concepts as solutions that meet the criteria set out above:

Tort Modification Package

— Caps on awards
— Structured settlements
— Eliminate joint and several liability, or

Alternative resolution of malpractice disputes through any of the following, but not limited to:

— Modified "No-Fault" or "Worker Compensation" approach
— Arbitration
— Screening panels
— "Trip Insurance"
— Other effective alternatives that might be identified

General solutions that would be considered upon the approval of the concepts contained in either Category 1 or 2:

— Strengthening risk management programs
— Strengthening the ability of the Board of Medical Examiners to deal with incompetent physicians
— Consider the feasibility of mandatory insurance for physicians (This concept is linked specifically to the elimination of the doctrine joint and several liability.)

— Support for changing the burden of proof for medical negligence from "the greater weight of evidence", to "clear and convincing evidence", and that the FMA legal counsel and appropriate defense attorneys be requested to offer an opinion as to the extent of benefit this change would present.
— Request that the Florida Legislature and the Florida Supreme Court continue to critically review the contingency fee system and potential inequities therein in order to maximize patient compensation in instances of medical malpractice.
— Support the need for development of legislation to provide additional information that may be necessary for the State Board of Medical Examiners to carry out disciplinary provisions of the Medical Practice Act in the most efficient manner possible.

Other Legislative Objectives of the FMA for the 1985 Session of the Legislature

— Support recommended changes to assure that only qualified and competent physicians are granted licensure to practice medicine in Florida.
— Support for the concept of regional designated trauma centers in Florida to provide for optimal care of the critically injured patient.
— Support for the Clean Indoor Air Act that prohibits smoking in public places, except in designated smoking areas.
— Support for continued funding for the Community Hospital Education Act to assist in residency training for primary care physicians.
— Opposition to authorize "Self-Care Consultants" to prescribe drugs contained in a formula without examination and diagnosis by a physician.
— Opposition to a $150,000 appropriation to establish a school of chiropractic in Florida.
— Opposition to mandate all insurance policies to include payment for chiropractic services.
— Opposition to authorize optometrists to use or prescribe drugs in diagnosis and treatment of medical problems of the eye.
— Opposition to mandated hospital staff privileges for non-physicians.
— Opposition to exemptions being created in the Medical Practice Act that would bypass present licensure requirements.

Supplemental Reports
Council on Legislation

Supplemental Report dated April 26, 1985, was filed and Supplemental Report dated April 30, 1985, was adopted.

Supplemental Report
Council on Legislation

Louis C. Murray, M.D., Chairman
Dated April 26, 1985

This is to update the report of the Council on Legislation. This report reflects the status of legislation as of April 26, 1985.

1. **Professional Liability and Tort Reform Proposals:** Because of the frequent and rapidly changing status of legislation relating to professional liability and tort reform, Delegates will be provided with a detailed and current report on the variety of legislation being debated by the Florida Legislature. At the time of this writing the Senate and House are voting on the elements to be contained in each chambers' respective products.
2. **Key Issues Contained in FMA's 1985 Legislative Program:**

— Support for legislation changing the burden of proof in medical negligence from "the greater weight of evidence" to "clear and convincing evidence" (SB 485, HB 90). SB 485 is in Senate Commerce Committee. HB 90 is in House Health Care and Insurance Committee.
— Support recommended changes to assure that only qualified and competent physicians are granted licensure to practice medicine in Florida (SB 1209, HB 1217). SB 1209 is in Senate Economic, Community and Consumer Affairs Committee. HB 1217 is in House Appropriations Committee.
— Support for the concept of regional designated trauma centers in Florida to provide for optimal care of the critically injured patient (HB 1003). No Senate bill has been filed. HB 1003 is in House Health and Rehabilitative Services Committee.
— Support for the Clean Indoor Air Act that prohibits smoking in public places, except in designated smoking areas (SB 204, HB 281). SB 204 is in Senate Governmental Operations Committee. HB 281 passed as a Committee Substitute in House HRS Committee.
— Support for continued funding for the Community Hospital Education Act to assist in residency training for primary care physicians. This concept will be considered by the Senate and House Appropriations Committees.
— Opposition to authorize "Self-Care Consultants" to prescribe drugs contained in a formula without examination and diagnosis by a physician (SB 636, HB 392). SB 636 is in Senate Economic, Community and Consumer Affairs Committee. HB 392 has been placed on the House Calendar.
— Opposition to a $150,000 appropriation to establish a school of chiropractic in Florida. This will be considered by House and Senate Appropriations Committees.
— Opposition to mandate all insurance policies to include payment for chiropractic services (SB 248, HB 170). SB 248 is in Senate Commerce Committee. HB 170 is in House Health Care and Insurance Committee.
— Opposition to authorize optometrists to use or prescribe drugs in diagnosis and treatment of medical problems of the eye. No bill has been filed in either House.

— Opposition to mandated hospital staff privileges for non-physicians (SB 303, SB 304, HB 519, HB 639). SB 303 has been placed on the Senate Calendar. SB 304 has been placed on the Senate Calendar. HB 519 is in House HRS Committee. HB 639 is in House HRS Committee.
— Opposition to exemptions being created in the Medical Practice Act that would bypass present licensure requirements (SB 1162, HB 1132). SB 1162 is in Senate HRS Committee. HB 1132 is in House Regulatory Reform Committee.
— Support for the establishment of day care programs and memory disorder clinics for persons suffering from Alzheimer's Disease (SB 212, HB 77). SB 121 is in Senate Appropriations Committee. HB 77 is in House Appropriation Committee.
— Support for raising the drinking age to 21 (SB 1, HB 42, HB 54). SB 1 is in Senate Finance and Tax Committee. HB 42 is in House Regulated Industries and Licensing Committee. HB 54 is on the House Calendar.
— Support for legislation prohibiting a physician from prescribing certain hormones for musclebuilding or enhancement of athletic perfomance (SB 380, HB 33). SB 380 was substituted by HB 33. HB 33 has passed both Houses and ordered enrolled.
— Support for legislation closing a loophole in the child restraining law (HB 6). No Senate bill has been filed. HB 6 is in House Appropriations Committee.
— Support for legislation requiring use of seatbelts (SB 144, HB 37, HB 47, HB 70). SB 144 is on the Senate Calendar. HB 37, 47, 70 were combined as a Committee Substitute and is in House Appropriations Committee.
— Support for legislation enhancing enforcement of quality of care by Department of Health and Rehabilitative Services for Health Maintenance Organizations (SB 573, PCB 1). SB 573 is in Senate Commerce Committee. PCB 1 is in House Health Care and Insurance Committee.
— Oppositon to expansion of Certificate of Need to physcian offices (SB 929, PCB 85-03). SB 929 is in Senate HRS Committee. PCB 85-03 is in House Health Care and Insurance Committee.
— Opposition to legislation mandating insurance payment for services provided by nurse anesthetists, advanced registered nurse practitioners, and psychologists (SB 305, SB 836, HB 518, HB 868). SB 305 is in Senate Commerce Committee. SB 836 is in Senate Commerce Committee. HB 518 is in House Health Care and Insurance Committee. HB 868 is in House Health Care and Insurance Committee.
— Opposition to legislation authorizing use of pitocin to augment labor in birthing centers (HB 854). No bill has been filed in the Senate. HB 854 was defeated on the House floor.
— Oppositon to legislation requiring identification of designated recipient of donated blood (SB 586). SB 586 is in Senate HRS Committee. No bill has been filed in the House.
— Oppositon to legislation permitting dentists who complete anesthesia residency at a medical school to administer nondental anesthesia (SB 1045). SB 1045 is in Senate Economic, Community and Consumer Affairs Committee. No bill has been filed in the House.
— Opposition to legislation limiting contributions by political action committees (PACs) (SB 168). SB 168 is in Senate Rules Committee.
— Opposition to legislation reenacting licensure of laymidwives (SB 1220, HB 991). SB 1220 is in Senate HRS Committee. HB 991 is in House HRS committee.
— Opposition to legislation creating Exclusive Provider Organizations (EPOs). No bill has been filed in either House.
— Opposition to legislation increasing physicians license renewal fees to fund health care for the indigent (SB 328, HB 272). SB 328 has been withdrawn. HB 272 defeated in House HRS Committee.

3. **Additional Major Health Legislation Filed**

a. **Continuation of regulation of naturopathic physicians (SB 246, HB 535):** SB 246 is on the Senate Special Order Calendar. HB 535 passed the House and is in Senate Economic, Community, and Consumer Affairs Committee.
b. **Wrongful Birth (SAB 245, HB 207):** Provides no person is liable in civil damages for any act or omission that results in a person being born alive instead of being aborted. SB 245 is in Senate Judiciary-Civil Committee. HB 207 is in House Judiciary Committee.
c. **Physician Licensing (CS/SB 340, HB 973):** Authorizes the State Board of Medical Examiners to issue distinguished scholar certificate to a physician to teach at a medical school. CS/SB 340 passed the Senate and is in House messages. HB 973 is in House Appropriations.
d. **Health Advocate (SB 369, HB 391):** Creates a Health Advocate to represent the public in all matters relating to the providing of health services. SB 369 is in Senate HRS Committee. HB 391 is in House Health Care and Insurance Committee.
e. **Mandatory Professional Liability Insurance (SB 412, HB 23):** Requires a physician to maintain not less than $500,000 in coverage as a condition of licensure. SB 412 is in Senate Commerce Committee. HB 23 is in House Judiciary Committee.
f. **Joint and Several Liability (SB 414, HB 569):** Provides the amount of damages awarded a party shall be apportioned according to the degree of fault. SB 414 is in Senate Judiciary-Civil Committee. HB 569 is in House Judiciary Committee.
g. **Second Surgical Opinion (CS/SB 467, CS/HB 149):** Requires second opinions prior to elective surgery in the state health insurance plan. Bill was amended to conduct pilot study. CS/SB 467 is in Senate Rules and Calendar Committee. CS/HB 145 is on House Calendar.
h. **Surgeons' Performance Records (SB 580):** Requires each hospital to maintain surgical performance records on elective surgery as a condition of licensure. SB 580 is in Senate HRS Committee. No bill has been filed in House.
i. **Medicaid Bidding (SB 676, HB 402):** Authorizes the Department of Health and Rehabilitative Services to contract with hospitals for Medicaid inpatient and outpatient services through competitive bidding or negotiations. SB 676 is in Senate HRS Committee. HB 402 is in House HRS Committee.
j. **Attorneys' Fees (SB 738):** Provides a sliding scale of attorney's fees and provides for screening panels in medical malpractice cases. SB 738 is in Senate Commerce Committee. No bill has been filed in House.
k. **Health Maintenance Organizations (SB 800):** Requires health maintenance organizations to make available care from chiropractors, podiatrists, and osteopaths at an added premium. SB 800 is in Senate HRS Committee. No bill has been filed in House.
l. **Children's Health Insurance (SB 948, HB 1031):** Requires insurers to provide coverage for children's health supervision until age 21. SB 948 is in Senate Commerce Committee. HB 1031 is in House Health Care and Insurance Committee.
m. **Negligence Actions and Damages (SB 1030):** Establishes a workers' compensation — no fault approach to resolving malpractice claims — The "Barron Plan." SB 1030 is in Senate Commerce Committee. No bill has been filed in House.

n. **"Sunrise Act" for Unregulated Professions (SB 1029):** Creates the "Sunrise Act" of 1985 to establish criteria to be considered by the Legislature when considering enacting laws to regulate previously unregulated function. SB 1029 is in Senate Governmental Operations. No bill has been filed in House.

o. **Certificates of Need (SB 1074):** Repeals the certificate of need process. SB 1074 is in Senate HRS Committee. No bill has been filed in House.

p. **Negligence Actions and Damages (SB 1023):** Provides for periodic payments for future losses over $100,000. SB 1023 is in Senate Commerce Committee. No bill has been filed in House.

q. **Physicians Insurance (SB 1055):** Requires physicians to have proof of financial responsibility as a condition of licensing, abolishes joint and several liability, and requires permission of court to plead punitive damages. SB 1055 is in Senate Commerce Committee. No bill has been filed in House.

r. **Patient's Compensation Fund (SB 1082):** Increases coverage amounts, provides limits of coverage for providers other than hospitals shall be exclusive of fund entry level amounts up to $4 million, shall be inclusive of fund entry level amounts in excess of $1 million, and shall not exceed $1 million per claim; provides a limit of $2.5 million per claim for hospitals; requires that assessments be sufficient to cover expected claims. SB 1082 is in Senate Commerce. No bill has been filed in House.

s. **Civil Actions/Damages (SB 1109):** Provides at any time in a civil action for money damages, any party may serve on an adverse party a written offer to compromise and settle the action; provides for acceptance or rejection of offers and for protection of minors; provides that an offeror whose settlement was rejected shall be entitled to recover from the adverse party if the offer was more favorable than the final judgement; provides the court may award litigation expenses and prejudgment interest penalites. SB 1109 is in Senate Judiciary-Civil Committee. No bill has been filed in House.

t. **Sovereign Immunity (SB 1121):** Waives sovereign immunity for liability arising from a breach of contract; provides no governmental employee shall be held personally liable or named as a party defendant; provides no limit on recovery for damages for bodily injury, wrongful death, or property damage; provides governmental liability does not include punitive damages; requires claims to be filed within 2 years; provides for offers of settlement and non-jury trials provides for apportionment of damages and for joint and several liability; provides a sliding scale for attorney fees based on the amount of damages awarded; requires governments to be insured for not less than $100,000 per person and $200,000 per incident; provides for structured payments on awards over $500,000. SB 1121 is in Senate Governmental Operations Committee. No bill has been filed in House.

u. **Medical Malpractice (SB 1229):** Requires licensed health facilities to investigate medical negligence or mental or physical impairment which may affect patient care; requires the Board of Medical Examiners and the Board of Osteopathic Medical Examiners to investigate physicians with two or more claims for malpractice in a five year period; provides medical malpractice insurance or self-insurance policies shall include sections relating to cooperation of the insured and rights of the insurer to settle without the insured's consent; requires insurance companies to report information on all claims to the Department of Insurance; provides the Department of Insurance shall notify the appropriate licensing board in the Department of Professional Regulation if it seems there are grounds for disciplinary action against a medical practioner; provides for periodic payments for future damages; provides for settlement offers of admission of liability and for arbitration. SB 1229 is in Senate Commerce Committee. No bill has been filed in House.

v. **Medical Review Panels (HB 348):** Establishes a medical review panel to hear claims before they may be filed in court. No bill has been filed in Senate. HB 348 is in House Health Care and Insurance Committee.

w. **Attorney Fees (HB 1176):** Requires the court to liberally construe the law which provides for attorney's fees to the prevailing party when the court finds there was an absence of a justifiable issue of law or fact. No bill has been filed in Senate. HB 1176 passes the House and is in Senate Messages.

x. **Settlement Offers (HB 1267):** Provides that at any time more than 30 days before a trial begins any party may make an offer to settle a claim for money or property in a civil case; provides an offer not accepted within 30 days is deemed withdrawn; provides that if the final judgement is not more favorable than the unaccepted offer, the one turning down the offer must pay costs and expenses incurred by the offeror after the making of the offer. No bill has been filed in Senate. HB 1267 is on the House Calendar.

y. **Foreign Doctors (HB 1323):** Provides graduates of foreign medical schools whose supervised clinical training was completed prior to November 28, 1984, and who apply for licensure before August 15, 1985, are exempt from the supervised clincial training requirements established by the Board of Medical Examiners. No bill has been filed in Senate. HB 1323 is on the House Calendar.

The Council on Legislation asks for permission to introduce to the Reference Committee any item of major significance that might have arisen in the Legislature between April 26 and the time of the FMA Annual Meeting.

Supplemental Report
Council on Legislation

Louis C. Murray, M.D., Chairman
Dated April 30, 1985

This is to update the Report and Supplemental Report (April 26, 1985) of the Council on Legislation. This report reflects the status of professional liability legislation as of April 30, 1985.

1. **House Medical Malpractice Reform Bill (HB 1352):** Current Status — Reported favorably by House Health Care and Insurance Committee on April 29, 1985 to House Appropriations and Finance and Tax Committees, with Floor action scheduled for the week of May 6th. Summary — Major points include triggered review of negligent physicians; increased risk management requirements; imposition on hospitals of responsibility for medical staff negligence; the creation of a special risk category within the Florida Medical Malpractice Joint Underwriting Association providing for a guaranteed maximum medical malpractice insurance premium; requirement for mandatory insurance; a 90 day presuit screening process; limitations on contingent attorney fees.

2. **The Major Provisions of the Bill:**

   a. Make it mandatory for governing boards to investigate and determine whether good cause for discipline exists. If good cause is found to exist, the boards are required to

take some disciplinary action. The definition of "good cause" is also amended to include medical malpractice involving negligent conduct. The bill provides the Board or review committee with immunity from liability for any action taken without intentional fraud. The bill also extends such immunity to investigators, witnesses, or other persons carrying out the provisions of this disciplinary section.

b. Include a list of grounds for disciplinary action against a physician which may be taken by the Board of Medical Examiners. Presently, it is grounds for discipline if there is "gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances." The bill specifies that "repeated malpractice" includes, but is not limited to, having two or more claims for malpractice within the previous 5-year period resulting in a judgment or monetary settlement exceeding $10,000 and where each case involved negligent conduct. The bill requires the Board to investigate and determine if disciplinary action is warranted upon being notified by the Department of Insurance of a physician's having two or more paid claims (judgment or monetary settlement).

c. The bill expands the civil immunity provided to members of a medical review committee of a health care facility or professional society for acts performed within the scope of the functions of the committee. The immunity is not provided if the member acts with intentional fraud. The bill also extends this immunity to any person acting within the scope of the committee, including witnesses, reporters, and investigators. The immunity is further extended to persons acting within the scope of the functions of a peer review committee of an insurer. Health care facilities have a duty to review medical staff's competence. Health care providers must cooperate with the review. Medical malpractice liability is not affected. Penalties and restrictions on persons bringing suits against review committees are imposed.

d. Standards for medical negligence are rewritten in terms of the prevailing professional norm as opposed to the existing "accepted standard of care." Qualifications for medical experts are tightened to require practice or teaching within 5 years before the incident. Failure to order medical diagnostic testing is not actionable if carried out in good faith and with due regard for the standard of care.

e. In medical malpractice cases, certification by a plaintiff's attorney that a reasonable investigation of the case has been conducted is required by the proposed bill. This may be based on a written medical expert opinion. Claims for punitive damages may not be pled initially, but only with the permission of the court after an evidentiary showing of a reasonable grounds for the claim. These provisions are intended to discourage unfounded suits and spurious claims for punitive damages.

f. In any medical malpractice action in which the trier of fact makes an award for future damages which exceeds $500,000, the parties would be given the option of periodic payments.

g. Ninety days prior to filing a malpractice claim, a claimant would be required to file a notice of intent to initiate litigation. The defendant's insurer would be required to conduct a peer review process during this 90-day period. At the end of this presuit screening period the insurer may (1) reject the claim, (2) make a settlement offer, or (3) make an admission of liability and an offer to arbitrate the damages. A prospective defendant may make this third response contingent on a limitation of general damages. Claimant's counsel is required to give the claimant a formal opinion letter regarding any response. If a settlement offer is made and accepted within 90 days, the claimant's attorney fees are limited to 15 percent of the settlement. If offer (3) is made, the plaintiff may reject it and file suit. If the plaintiff accepts it, the parties go to arbitration and the arbitration award is binding. The intended purpose of this section is to encourage prompt settlement of meritorious claims.

h. A schedule of attorney contingent fees is established by the bill. The schedule will take effect on April 1, 1986 unless the Supreme Court of Florida adopts guidelines for the regulation of contingent fees. The schedule ranges from 15 percent to 45 percent and increases as the case moves through the various steps of the litigation process. For those amounts of a recovery in excess of $2 million, the maximum fee is 15 percent.

i. The powers of the trial court to review jury awards for excessiveness and inadequacy are extended. The current limitation of "clearly" excessive or inadequate is deleted. Trial courts are required to closely scrutinize awards for general damages exceeding $250,000 and those less than $5,000. General damages must bear a reasonable relation to the injury. On appeal, the trial court's action is not reversible if supported by substantial, competent evidence.

j. The bill provides that hospitals shall be vicariously liable for negligent acts of its staff, except for acts or omissions related to non-invasive diagnosis.

k. A special risk category is established for high risk doctors with a premium cap of the greater of $5,000 or 15 percent of the doctor's gross income. The deficit created by this cap is initially funded through a 10 percent premium surcharge on medical malpractice insurance premium. The remaining deficit is recovered from the medical malpractice insurers. Any additional deficits are to be collected from insurers who are members of the Florida Medical Malpractice JUA.

l. The bill requires financial responsibility (escrow or insurance) for physicians. The requirement will be phased in over three years.
$500,000 ($750,000 aggregate)/ Oct. 1, 1985-Sept. 30, 1986; $750,000 ($2.2 million aggregate)/Oct 1, 1986-Sept. 30, 1987; thereafter $1 million ($3 million aggregate).

m. The proposal calls for mandatory CME in the amount of a minimum of 60 hours every two years of which six hours is in risk management. Criteria and content of CME courses shall be approved by the Board of Medical Examiners. The Board may consider equivalent national or state educational courses to fulfill part or all of the requirement.

n. The bill establishes certain minimum standards for optional arbitration provisions in certain group HMO/PPO insurance contracts.

The bill presently does not include provisions dealing with the abolition of joint and several liability or limitations on general damages.

3. **Senate Action on Tort Reform/Medical Malpractice (SB 1055, SB 1232):** On Monday, April 29, the Senate Commerce Committee adopted two key bills that should soon go to the Senate floor:
SB 1055. This bill:
   a. Abolishes the Doctrine of Joint and Several Liability.
   b. Requires hearing before a judge prior to pleading for punitive damages.
   c. Requires professional liability insurance in amount of $250,000/$750,000 for all M.D.s and osteopaths.

SB 1232. This bill contains provisions revising the procedures for certification of foreign health care education institutions, mandatory continuing medical education of 30 hours every two years, and repeal of the statute on recovery of attorney fees ("loser pays"). In the committee, the following amendments were added and incorporated into CS/SB 1232:

a. Authorization for sale of professional liability insurance on a group basis to associations and organizations.
b. Clarification of constitutional issue in Informed Consent Law.
c. Improves remittitur and additur provision by removing "clearly" from criteria for determination of excessive or inadequate awards.
d. Prohibits insurance contracts from giving insured veto power over offeres, and requires 60 days notice before cancellation of a contract.
e. Allows insurer to require membership in a state or local society which maintains a medical review committee.
f. Sets up non-binding arbitration system to replace mediation panels. Contains penalties for refusal of decision if later court award varies from arbitration recommendation by more than 25 percent.

There hav been several other bills filed relating to the issue of professional liability, but none have received committee action to date.

The motion that the House of Delegates go on record to actively oppose and work to defeat mandatory malpractice insurance tied to licensure and that if the Legislature mandates malpractice insurance that the Board of Governors consider authorizing legal counsel to immediately test the law's constitutionality, carried.

Report D of the Board of Governors

The motion of the Reference Committee that Report D of the Board of Governors be adopted as corrected carried.

Report D of the Board of Governors

Frank C. Coleman, M.D., Chairman

Board Actions of Major Importance

The Annual Reports on the major activities of FLAMPAC and the Council on Legislation are included in this section of the Delegates' Handbook. The Board has carefully reviewed the activities of FLAMPAC and the Council during the past Association year and the Council's recommendations regarding important legislative issues to be addressed during the 1985 Session of the Florida Legislature. The Board submits the following report and/or recommendations to the House regarding each of the items addressed by FLAMPAC and the Council on Legislation.

FLAMPAC

Membership: The Board expressed commendations to FLAMPAC for the significant improvements achieved in the number of physicians and their spouses joining FLAMPAC as sustaining. The Board also noted that FLAMPAC was on the winning side in a large number of races during the 1984 elections and that an increasing number of physicians and their spouses had participated directly as volunteers in many of the campaigns.

FLAMPAC Board of Directors: In accordance with the FLAMPAC Bylaws, the Board of Governors approved appointments to the FLAMPAC Board of Directors for 1985 as reflected in the Report of FLAMPAC, Reference Committee III, blue, in the Delegates' Handbook, plus the following additional appointments to fill current vacancies:

Florida Congressional District 8	James L. West, M.D.
Florida Congressional District 11	Brian A. Gibbons, M.D.
Florida Congressional District 15	T. W. Hahn, M.D.
Member from the State At Large	Richard S. Hodes, M.D.
Member from FMA Auxiliary	Mrs. Donald G. Nikolaus

COUNCIL ON LEGISLATION

1984 Legislative Session: The Board received an extensive report on the actions taken on major health issues by the 1984 Legislature. It was noted that the 1984 Session again presented a significant challenge, both from the number of anti-medicine issues as well as the disappointment of the complete failure of the Legislature to address the professional liability issue. A complete report on health issues acted on by the Legislature is summarized in the Annual Report of the Council on Legislation included in the Delegates' Handbook.

1985 Legislative Session: The following is a summary of the FMA legislative priorities approved by the Board for the 1985 Session. Additional items and information on legislative issues affecting physicians and health care are included in the Report of the Council on Legislation in the Delegates' Handbook or will be included in a Supplemental Report of the Council which will be distributed to Delegates at the Annual Meeting.

Professional Liability: The Board of Governors and the FMA House of Delegates at its special Called Meeting on January 28, 1984, reaffirmed professional liability as a major legislative priority. Bills were introduced in the House and Senate for consideration by the 1984 Legislature which embody the same proposals as those approved by the House of Delegates for the constitutional initiative campaign including:

- Summary judgments;
- Limitations on noneconomic damages;
- Elimination of joint and several liability.

The support in the Senate for the FMA's tort reform proposals was overwhelming, as it was during the 1983 session. Unfortunately the Speaker of the House, a trial lawyer, once again, as he did in 1983, refused to even allow debate on the professional liability issue. As a result, nothing happened during the 1984 session, and the FMA was forced to take the professional liability problem to the citizens of Florida through the constitutional initiative process. A complete report on the Reason '84 Constitutional Initiative Campaign and the continuing activities of the FMA in seeking lasting and effective solutions to the professional liability crisis in our state is included in Board Report C in the Delegates' Handbook. Resolution of the professional liability dilemma will remain the number one legislative priority of the FMA during the 1985 session.

The Board directed that following completion of the report of the Governor's Task Force on Medical Malpractice that FMA introduce, during the 1985 Session of the Florida Legislature, legisla-

tion which embodies those concepts for tort reform through the legislative process or other remedial actions as approved by the Board of Governors at its meeting in January 1985 including a concept for a limitation on general (noneconomic) damages:

THAT THE FMA BOARD OF GOVERNORS APPROVE SUPPORT OF SOLUTIONS FOR RESOLVING THE PROFESSIONAL LIABILITY THAT WILL ACHIEVE STABILITY IN RESPECT TO THE CURRENT COST OF PROFESSIONAL LIABILITY INSURANCE AND WILL PROVIDE TO PATIENTS WHO ARE TRULY INJURED IN THE MEDICAL SYSTEM AN OPPORTUNITY TO BE ADEQUATELY ^ND EFFICIENTLY COMPENSATED FOR THEIR INJURIES; AND FURTHER, THAT THE FMA SUPPORT THE FOOLLOWING CONCEPT A SOLUTIONS THAT MEET THE CRITERIA SET OUT ABOVE:

1. TORT MODIFICATION PACKAGE
   A. CAPS ON AWARDS
   B. STRUCTURED SETTLEMENTS
   C. ELIMINAT JOINT AND SEVERAL LIABILITY, OR
2. ALTERNATIVE RESOLUTION FOR MALPRACTICE DISPUTES THROUGH ANY OF THE FOLLOWING, BUT NOT LIMITED TO:
   A. MODIFIED "NO-FAULT" OR "WORKER COMPENSATION" APPROACH
   B. ARBITRATION
   C. SCREENING PANELS
   D. "TRIP INSURANCE"
   E. OTHER EFFECTIVE ALTERNATIVES THAT MIGHT BE IDENTIFIED
3. ADDITIONAL CONSIDERATIONS:
   A. STRENGTHENING RISK MANAGEMENT PROGRAMS
   B. STRENGTHENING THE ABILITY OF THE BOARD OF MEDICAL EXAMINERS TO DEAL WITH INCOMPETENT PHYSICIANS
   C. CONSIDER THE FEASIBILITY OF MANDATORY INSURANCE FOR PHYSICIANS (THIS CONCEPT IS LINKED SPECIFICALLY TO ITEM I(C) JOINT AND SEVERAL LIABILITY.)

Physician Discipline: The Board recognized the need for development of legislation to provide additional information that may be necessary for the State Board of Medical Examiners to carry out disciplinary provisions of the Medical Practice Act in the most efficient manner possible. The Board endorsed the concept requiring information on paid claims to be sent from the Department of Insurance to the Department of Professional Regulation:

> "The department shall screen the reports annually and send to the Department of Professional Regulation and the appropriate regulatory board, copies of the reports for all health care providers having paid claims."

And, endorsement of the Department of Professional Regulation recommendations as follows:

1. The penalty for knowingly giving false information when obtaining a license as a health care practitioner (licensed under Chapters 458, 459, 460, 462, 463, 464, 465, 474 and 490, Florida Statutes) will be a third degree felony. This proposal will amend Chapter 455, Florida Statutes.
2. Obtaining a license to practice medicine by fraudulent misrepresentation or fraudulently misrepresenting education, training or experience in obtaining a position as a medical practitioner or medical resident, will result in a third degree felony penalty. This change is proposed for both Chapters 458 and 459, Florida Statutes.
3. The number of times an individual may take the FLEX for state licensure will be limited to three. After failing three times, the applicant will be required to take one year of post graduate training in a program approved by the AMA prior to attempting the examination for a fourth, and final, time. The post graduate training is the responsibility of the individual.

Workers' Compensation Fee Schedule: The Board directed that FMA continue to aggressively pursue via the administrative process, the resolution of inequities in the Workers' Compensation fee schedule, and that the adoption of any specific legislative objectives of the FMA be deferred for the time being.

Indigent Care: The Board approved the development of recommendations to submit to the proper governmental authorities to address the issue of adequate health care for the indigent, and further, that the Council be requested to proceed with the recommendation in concert with the Council on Legislation.

Health Care Cost Containment: The Board determined that the FMA place maximum emphasis on developing a plan of action, both legislative and executive, to be considered in addressing the health care cost issue in 1985.

Other Legislative Issues: The Board adopted general positions on other legislative issues as follows:

Support For:

Foreign Medical Graduates: The Board recommended changes that are to be developed by the appropriate representative of the medical schools in Florida and the FMA Council on Scientific Activities in concert with existing state boards and agencies, to assure that only qualified and competent physicians are granted licensure to practice medicine in Florida.

The Board expressed support for legislation by the Department of Professional Regulation that would prohibit licensure of physicians who are graduates from foreign medical schools except by the following criteria:

1. Only those physicians who are graduates from foreign medical schools which are certified or accredited by a nationally recognized certifying or accrediting agency as a result of an on-site visit to the foreign medical school.
2. Only those physicians who have completed minimum requirements for training and licensure in an AMA approved and accredited residency training program.

Alzheimer's Disease: Creation of an advisory committee on Alzheimer's Disease, the Alzheimer's Disease Research Trust Fund and specialized model day care programs (HB77 & SB121).

Indigent Health Care: Support indigent health care funding by additional taxes on such revenue sources as alcohol and tobacco.

Clean Indoor Air Act: Establishment of the Clean Indoor Air Act that prohibits smoking in public places except in designated smoking areas.

Community Hospital Education Council: Increased funding for the Community Hospital Education Council.

Mandatory Car Seat Belts: Requirement for an operator and passengers of a private motor vehicle to wear safety seat belts (HB37, HB47, HB70, SB141).

Trauma Centers: Concept of regional designated trauma centers in Florida to provide for optimal care of the critically injured patient.

Imminent Scholars Program: Support increased funding for imminent scholars fund.

Drinking Age: Raising the legal age for the consumption or possession of alcoholic beverages from 19 to 21 (HB42, HB54, SB1).

Child Safety Seats: Closes a loophole in the child restraint law that requires all persons transporting a child who is five years or younger in a motor vehicle to use a child restraining device (HB6).

Campaign Financing: Prohibits contributions to candidates who are unopposed to be made after the qualifying date.

Opposition To:

Pharmacy Prescribing: Authorization for certain "Self-care Consultants" to prescribe drugs contained in a formulary without examination and diagnosis by a physician.

Mandated Insurance for Chiropractic Services: Mandates for all insurance policies to include payment for chiropractic services.

Chiropractic School: Any appropriation from general revenue to establish a school of chiropractic in Florida.

Mandatory PLI: Mandates professional liability insurance in the amount of $250,000 for all physicians on a condition for license (HB 23).

Limitation of Expenditures by PACS: Sets up certain limitations on the amount of PAC contributions to candidates.

Use of Drugs by Optometrists: Authorization for optometrists to use or prescribe drugs in diagnosis and treatment of medical problems of the eye.

Hospital Staff Privileges for Non-Physicians: Mandated hospital staff privileges for non-physicians.

Amendments to Medical Practice Act: Any further exemptions being created in the Medical Practice Act would bypass present licensure requirements.

Increased Fees for Physician Licenses: Requires an increase in physicians licensure fees to fund Medicaid.

Review of FMA Legislative Activities

The Florida Medical Association has had a legislative program for many years. In 1969, the FMA established a Capital Office in Tallahassee with a full-time legislative director and supporting staff. Because of the early realization of the relationship between effective political action and successful legislative efforts, the FMA was one of the first state medical associations to establish a political action committee (FLAMPAC). Field offices of the FMA with field directors are now located in Tallahassee, Tampa, Orlando, and Miami.

A key man system (key contact program) was developed many years ago with a physician designated as the key man for each member of the Legislature and Congress. Over the last decade, the FMA has also developed a strong working relationship with the FMA Auxiliary in both political and legislative activities. The Auxiliary has become a very strong force in community action and has established a comparable key contact system which works in close cooperation with that of the FMA. The Auxiliary also established a LegsAlert system that has proven to be very effective on behalf of the FMA in dealing with legislative issues which require immediate action.

Our experiences in the legislative sessions in 1983 and 1984 relative to the professional liability issue and our recent experience with Amendment 9, indicated clearly that we needed to carefully examine the legislative arm of the FMA to see whether it is meeting the demands of a rapidly changing environment.

The Board of Governors, therefore, authorized a review of the legislative program. A team of consultants consisting of Mr. Bill Roberts, AMA Division of Medical Society Relations; Mr. Bob Klinglesmith, Associate Executive Director of the Kentucky Medical Association; and Mr. Greg Hooser, Legislative Counsel of the Texas Medical Association were asked to come to Florida and make a detailed on-site review of the Association legislative and political education activities. This review was to include the FMA's legislative, PAC, field services activities, its relationships with the Auxiliary, county and specialty medical societies, and other groups in the health field that have legislative interests and concerns.

The review has now been completed and a detailed report has been received which indicates that generally the FMA's legislative efforts have been historically very effective, and with the exception of its tort reform effort, compares very favorably with that of most other state medical societies. We must recognize, however, in light of Dr. Sammons' remarks, that Florida is now a bell weather state for change. Therefore, we must continue to respond to the rapid, revolutionary changes that are occurring, and our legislative program should be strengthened in every way possible.

This report and the recommendations of the consultants have received very careful review, and steps are already underway to implement the recommendations which include:

1. Careful evaluation of all staff responsibilities for the FMA legislative and political education activities with appropriate action as necessary to clarify and delineate the role, lines of authority and responsibilities and functions of the FMA headquarters, capital and field offices to ensure the best possible coordination and operational efficiency in carrying out these activities.
2. Expand the responsibilities of the Council on Legislation in carrying out the policies of the House of Delegates using general guidelines established by the Board of Governors.
3. Strengthen working relationships with county medical societies with these efforts directed both at the executives of the county medical societies and the physician members.
4. Strengthen and expand the cooperative efforts with the Auxiliary in our legislative and political education activities.
5. Develop a better working relationship with specialty societies and their lobbyists, if these societies have such lobbyists.
6. Develop a better working relationship with other groups such as business organizations, labor unions, civic and senior citizen organizations.
7. Improve liaison with the executive and regulatory branches of the Florida Government.
8. Incorporate in the FMA legislative program issues other than those that are perceived by the public and the legislature to be solely for the benefit of physicians.
9. Expand FLAMPAC activities to include more assistance to candidates such as benchmark surveys, demographic studies, independent expenditures and more physician and spouse participation in the candidates' campaigns.
10. Maximize efforts to keep physicians informed of the Association's legislative programs and activities.

Kenneth C. Kiehl, M.D., Sarasota, Chairman, Reference Committee No. IV, presents his Reference Committee report.

This analysis and refinement of the FMA's legislative arm of the FMA will greatly enhance the legislative capability in 1985 and in the future, to cope with the numerous, complex, and at times the seemingly overwhelming legislative problems that face medicine.

The motion of the Reference Committee that the portions of the Council on Specialty Medicine Report referred to this committee be filed carried.

The motion of the Reference Committee that the portions of the Board of Governors Report A referred to this Committee be filed carried.

The motion of the Reference Committee that the portions of the Board of Governors Report B referred to this Committee be filed carried.

RESOLUTION 85-5
Assignment of Insurance Benefits
Dade County Medical Association

A Substitute Resolution 85-5 was offered by the Reference Committee and its adoption moved. The motion carried and Substitute Resolution 85-5 was adopted.

Substitute Resolution 85-5
Assignment of Insurance Benefits

RESOLVED, That the FMA Board of Governors be asked to consider undertaking legislative efforts immediately to change Florida Statute 627.736 (which currently allows insurers to honor signed assignments) to provide that insurers shall honor signed assignments, and to provide further that whenever previously signed assignments are changed, all affected parties be notified by the insurer.

RESOLUTION 85-8
Expert Testimony Requirements
Dade County Medical Association

The motion of the Reference Committee that Resolution 85-8 be referred to the Board of Governors carried.

Resolution 85-8

Expert Testimony Requirements

(Referred to Board of Governors)

Whereas, Malpractice premiums are exorbitant in certain areas of the state; and

Whereas, An expert witness is, by definition, practicing medicine in the state of Florida; and

Whereas, We are plagued by physicians from outside the state and without licenses to practice medicine in the state of Florida testifying in malpractice cases; therefore be it

RESOLVED, That the FMA take immediate action to promote the passage of state legislation requiring that any physician offering expert testimony in any malpractice case in Florida be licensed to practice in the state and be familiar with the medical practices in the community where the alleged malpractice occurred.

RESOLUTION 85-9
Mandatory FMA Membership
Dade County Medical Association

The motion of the Reference Committee that Resolution 85-9 be referred to the Board of Governors carried.

RESOLUTION 85-9

Mandatory FMA Membership

(Referred to Board of Governors)

Whereas, Physicians are constantly being harangued to "clean our own houses;" and

Whereas, There is presently no state legislation allowing for such actions; and

Whereas, A physician need not be a member of organized medicine to practice medicine in this state; and

Whereas, The county and state medical associations are best suited to monitor errant physicians; therefore be it

RESOLVED, That the FMA seek the passage of legislation mandating membership in the Florida Medical Association as a prerequisite for maintaining a Florida medical license and for hospital staff privileges with reference to Doctors of Medicine and osteopathy; and be it further

RESOLVED, That the FMA seek the passage of legislation allowing for some autonomy of the state and local medical societies for disciplining their members.

RESOLUTION 85-12
Limitations to Medical Malpractice Liability
Dade County Medical Association

RESOLUTION 85-16
Workmen's Compensation Approach to Medical Liability Insurance
Lee County Medical Society

Substitute Resolution 85-12, combining Resolutions 85-12 and 85-16, offered by the Reference Committee was referred to the Board of Governors as amended.

Substitute Resolution 85-12
Limitations to Medical Malpractice Liability
(Referred to Board of Governors)

RESOLVED, That medical liability on a no-fault and "workers' compensation" basis, with pre-determined limits of liability, be endorsed as a viable alternative to the present tort system.

RESOLUTION 85-18
Motorcycle Insurance Requirements
Lee County Medical Society

The motion by the Reference Committee that Resolution 85-18 not be adopted carried.

RESOLUTION 85-19
SBME Licensure Renewal Procedures
Polk County Medical Association

A Substitute Resolution 85-19 was offered by the Reference Committee and its adoption as amended moved. The motion carried and Substitute Resolution 85-19 was adopted as amended.

SUBSTITUTE RESOLULTION 85-19
SBME Licensure Renewal Procedures

RESOLVED, That the FMA seek establishment of appropriate mechanisms that would enable the FMA to contact physicians and their county medical societies when a medical license has not been renewed.

RESOLUTION 85-24
Medical Licensure
Duval Medical County Society

The motion by the Reference Committee that Resolution 85-24 be adopted carried.

RESOLUTION 85-24
Medical Licensure

RESOLVED, That the Florida Medical Association reaffirm its position to actively oppose any proposed legislation providing exception under the Medical Practice Act; and be it further

RESOLVED, That the Florida Medical Association inform all parties seeking exception to the Medical Practice Act of its position on this issue, and request those parties to cease their attempts to seek these exceptions.

RESOLUTION 85-25
HMO Financial Responsibility
FMA Council on Hospital Medical Staffs

A Substitute Resolution 85-25 was offered by the Reference Committee and its adoption as amended moved. The motion carried and Substitute Resolution 85-25 was adopted as amended.

SUBSTITUTE RESOLUTION 85-25
HMO Financial Responsibility

RESOLVED, That the Florida Medical Association seek passage of legislation (and/or modification of legislation currently being considered) to require HMO's to meet their financial responsibility to patients, physicians, and hospitals in the circumstance when a patient is given emergency care in a hospital for that which is considered by the physician or physicians delivering such care to be a bona fide emergency, and the HMO does not arrange timely provisions of services, and the physician or hospital are unable to obtain timely authorization for such care; and be it further

RESOLVED, That legislation be immediately sought to require HMO reimbursement of non-participating physicians within a reasonable time period (i.e., within thirty (30) days after delivery of care).

The Chairman expressed, on behalf of the Committee, his deep appreciation to FMA Staff, Mr. Donald Weidner, Mrs. Lucy Mohs, and Mrs. Diane Bowker for their assistance in the preparation of this report. The Committee also thanked all members of the Florida Medical Association who appeared before this Committee. The Chairman also thanked the members of this Committee, Dr. David R. Arrowsmith, Dr. Thomas R. Busard, Dr. E. Joan Barice, Dr. Charles A. Dunn, Dr. Arnold L. Tanis, Dr. Samuel L. Renfore, Dr. Louis C. Murray, AMA Delegate Advisor, and Dr. Sanford Mullen, AMA Alternate Delegate Advisor.

The motion that the report of Reference Committee IV be adopted as amended carried.

Report of Reference Committee No. V Medical Economics

Dr. Perry called the Chairman and members of the Reference Committee No. V, Medical Economics, to present their report.

Dr. Charles P. Hayes Jr., Chairman, and his Committee came forward to present the report of Reference Committee No. V, Medical Economics.

Report of the Council on Medical Economics

The motion of the Reference Committee that the Report of the Council on Medical Economics and the Supplemental Report of the Council on Medical Economics be filed carried.

Council on Medical Economics

Charles P. Hayes Jr., M.D., Chairman

The Council on Medical Economics held four meetings during the 1984-85 Association year: July 13, 1984, September 13, 1984, December 21, 1984, and February 18, 1985. The Council reviewed many medical economics issues during the Association year. The establishment of several subcommittees under the purview of the Committee on Health Care Delivery allowed many specific issues relating to medical economics to be addressed. Under the Committee on Health Care Delivery, four subcommittees were established including the Subcommittee on Business Coalition, Subcommittee on Government Programs, Subcommittee on Health Care Financing, and the Subcommittee on Health Care Delivery Mechanisms. These Subcommittees reviewed a tremendous amount of material and presented several recommendations to the Board of Governors. Major effort was devoted to the development of the Florida Medical Foundation Peer Review Organization proposal (FMF-PRO) that was submitted to the Health Care Financing Administration, the development of testimony was presented to the Three-Member Panel to request that an increase be granted to the Workers' Compensation Femur data base, and initiation of the development of the revised 1986 Florida Relative Value Studies. All the Committees under the Council on Medical Economics were very active. A summary of these activities is reported below.

Committee on Workers' Compensation

The Committee on Workers' Compensation, chaired by Howard A. Kurzner, M.D., presented testimony to the Three Member Panel on two separate occasions during the 1984-85 Association year supporting the establishment of an increase in Workers' Compensation fee schedule. Information presented to the panel included a statistical analysis comparing the Workers' Compensation Femur data base reimbursement rates and private health insurance program reimbursement rates for similar procedures. In addition, presentations were given on the effect of increasing price levels on the economic status of doctors, the effect of changing maximum allowances on the cost of medical care in Florida, and an analysis of the appropriate increases needed for Workers' Compensation maximum reimbursement allowances for Medical Services. Additionally, a survey was conducted by Florida State University that illustrated the percentage of doctors satisfied with the Workers' Compensation fee schedule, the number of doctors currently treating Workers' Compensation patients, and the increase or decrease in the percentage of Workers' Compensation patients treated by physicians. In addition, the survey also illustrated responses to questions pertaining to satisfaction with the fee schedule broken down by the various practice specialties and the Medicare charge areas. Additional testimony presented included comparing changes in the consumer price index, inflation rates, and cost of living increases as compared with physicians office practices expenses. As a result of the testimony that was presented to the Three-Member Panel, a 4.2% increase in the reimbursement schedule was granted in January, 1985, which will go into effect July 1, 1985.

Committee on Peer Review Organizations

The Committee on Peer Review Organizations, chaired by Charles P. Hayes Jr., M.D., was responsible for assisting the Professional Review Organization of Florida, Incorporated, in developing a PRO proposal to be submitted to the Health Care Financing Administration. A great deal of time and staff effort was devoted to the development of the PRO proposal. Unfortunately, the Foundation was unsuccessful in its bid for the PRO contract for the State of Florida. The FMA has filed protest with the General Accounting Office as a result of what appears to have been major flaws in the awarding of the contract and is awaiting a final decision of the protest. Also, a suit has been filed with the Federal District Court in Washington, D.C., under the Freedom of Information Act as a result of the Health Care Financing Administration's failure to supply pertinent information pertaining to the negotiation and contract procedures. The final proposal submitted by the Florida Medical Association was a detailed, four volume report totaling over 700 pages of material. The PRO Committee has been actively monitoring the activities of the Professional Foundation for Health Care and has requested county medical societies to submit any problems they have encountered with the implementation of PRO. The Committee has studied these problems and has met with Professional Foundation for Health Care representatives to try to eliminate some of the problems that the membership has identified.

Committee on Relative Value Studies

The Committee on Relative Value Studies, chaired by Joel W. Mattison, M.D., is currently in the process of developing a revised

Reference Committee V (Medical Economics) was chaired by Charles P. Hayes Jr., M.D., Jacksonville. Left to right: John M. Canakaris, M.D., Bunnell; Robert L. Dawson, M.D., St. Petersburg; Jack W. MacDonald, M.D., Tallahassee; Charles B. McIntosh, M.D., Jacksonville; Dr. Hayes; Ms. Lynn Mobarak, Recorder; Miguel Figueroa, M.D., North Miami Beach; Ralph E. Rydell, M.D., Tampa; Dick L. Van Eldik, M.D.; Lake Worth; Joseph C. Von Thron, M.D., Cocoa Beach; Alan J. Yesner, M.D., Fort Lauderdale.

edition to the *1982 Florida Relative Value Studies* to be entitled *1986 Florida Relative Value Studies Book*. The revised Relative Value Studies will be based on the AMA CPT-4 1985 edition in its entirety. It will also be based on the 1983-84 Charge Data. Throughout the Association year, the Committee has maintained regular correspondence with physicians who had questions pertaining to the Relative Value Studies and have worked with the various specialty societies in addressing specific problems relating to the RVS. It is anticipated that the publishing of the 1986 Florida RVS will be completed sometime in late 1985.

Committee on Health Care Delivery

The Committee on Health Care Delivery, chaired by William J. Garoni, Jr., M.D., was quite active with 26 major recommendations to the Council on Medical Economics emanating from its four subcommittees, which proved to be an effective method in which to deal with the responsibilities assigned to the Committee. In general, the Committee and its subcommittees placed major emphasis on making proactive recommendations on many issues including the legislature's newest cost containment bill, the landmark Health Care Consumer Protection and Awareness Act of 1984, Chapter 84-35 Laws of Florida.

Subcommittee on Business Coalition

The Subcommittee on Business Coalition, chaired by Thomas E. McKell, M.D., reviewed a survey on business coalitions sent to all county medical societies, which disclosed that there are seven business coalitions in Florida. They are:

(1) South Florida Health Action Coalition
(2) Palm Beach Area Health Coalition
(3) Employer Health Care Group of Polk County
(4) Hillsborough Coalition for Health
(5) Central Florida Health Coalition
(6) Pasco County Health Care Coalition
(7) Health Care Cost Containment Coalition of the Greater Jacksonville Chamber of Commerce

It was noted that involvement with business by the county medical society in conjunction with the chamber of commerce provides a potentially good mechanism for county coalitions to develop cost containment health plans. The Subcommittee on Business Coalition recommended that the Technical Assistance Panel be established within the Florida Medical Association to identify cost-effective medical practice procedures to assist county medical societies in their involvement with business coalitions. The panel would also enable the Florida Medical Association to have a formal mechanism to provide technical information on the practice of medicine to the Office of Technical Assistance created by the Health Care Consumer Protection and Awareness Act.

Subcommittee on Health Care Delivery Mechanisms

The Subcommittee on Health Care Delivery Mechanisms, chaired by Robert G. Isbell, M.D., stressed the importance of medical economics and the need for the Florida Medical Association to monitor and report on the development of PPOs, HMOs, IPAs, and various hospital programs that affect the practice of medicine in this state. It further recommended that the Florida Medical Association develop a physicians guide on contracting and negotiating with alternative health delivery systems and hospital programs. In emphasizing long-range planning, the Subcommittee articulated the need to review the primary care and prepaid Medicaid program of the Department of Health and Rehabilitative Services and the financing on contract with private practice physicians.

Subcommittee on Health Care Financing

The Subcommittee on Health Care Financing, chaired by Jack W. MacDonald, M.D., identified as a critical concern the Florida Medical Association's need to interface with health insurance companies. The Subcommittee recommended that the new Health Care and Insurance Committee of the House of Representatives might serve as the forum for organized medicine and insurance companies to jointly develop health insurance plans involving the practice of medicine. It further felt that the programmatic staff of the Florida Medical Association needs to be involved with

the Legislature in terms of providing direct expertise on a routine basis in the development of health legislation. Other recommendations involved working with the Health Care Financing Administration (HCFA), reporting on the impact of Diagnostic Related Groups (DRGs) on medical practice, and developing an effective mechanism to assess the quality of care in Health Maintenance Organizations.

Subcommittee on Government Programs

The Subcommittee on Government Programs, chaired by James K. Conn, M.D., expressed support for the Governor's State Plan, which includes the concepts of growth management and strategic planning. A major recommendation was the establishment of a Medical Assistance Panel to advise the Department of Health and Rehabilitative Services on the development of policy and programs. It further acknowledged the need for an informed membership by recommending that the 1986 Leadership Conference include a State Government Workshop. The Subcommittee on Government Programs throughout 1985-86 will continue to associate with government entities and programs to establish access for medical input in the development of state health policy.

Supplemental Report
Council on Medical Economics

This Supplemental Report updates the report of the Council on Medical Economics in order to include the Council's meeting of March 29, 1985, held in Tampa, at which David H. Pingree, Secretary of the Department of Health and Rehabilitative Services (HRS) was the featured guest, along with James T. Howell, M.D., Deputy Secretary. The purpose of the meeting was to describe the structure, functions, objectives, and recent recommendations of the Council on Medical Economics, in order to determine methods by which HRS and the Florida Medical Association (FMA) can work more closely to meet the health needs of Florida's citizenry.

The Chairman of the Council on Medical Economics and the Chairmen of the Council's committees and subcommittees each described the recommendations of the Council, as approved by the Board of Governors, which specifically relate to government. These recommendations are:

— Priority of Medical Planning
— Technical Assistance Panel and Exchange of Information
— Long Range Planning
— Indigent Care
— Primary Care
— Medicaid Alternatives
— House of Representatives Committee on Health Care and Insurance
— HMO Accreditation and Quality of Health Care
— Medical Assistance Panel
— State Government Workshop
— The Governor's State Plan and Cost Containment

Both Secretary Pingree and Dr. Howell complimented Dr. Hodes and the entire Council on Medical Economics on the positive interrelationship with governmental programs that their recommendations entail. At which point the Council on Medical Economics urged that the House of Delegates strongly endorse these recommendations as approved by the Board of Governors.

The annual Past Presidents' Breakfast is always a highlight. Seated (left to right): Robert E. Windom, M.D., Sarasota (1982); Joseph C. Von Thron, M.D., Cocoa Beach (1973); J. Lee Dockery, M.D., Gainesville (1983); former FMA Executive Vice President W. Harold Parham, D.H.A., Jacksonville; Jere W. Annis, M.D., Lakeland (1958); H. Philip Hampton, M.D., Tampa (1965); and Samuel M. Day, M.D, Jacksonville (1964). Standing (left to right): Louis C. Murray, M.D., Orlando (1977); T. Byron Thames, M.D., Orlando (1980); Jack A. MaCris, M.D., St. Petersburg, (1976); Sanford A. Mullen, M.D., Jacksonville (1981); Richard S. Hodes, M.D., Tampa (1979); Vernon B. Astler, M.D., Orlando (1980); O. William Davenport, M.D., Miami (1978); and George S. Palmer, M.D., Tallahassee (1966).

Secretary Pingree and Dr. Howell each discussed the operation of the Executive and Legislative Branches of Government, including a description of the budgetary process which for all executive agencies begins a year in advance of its consideration by the Legislature. For example, the current budget now before the Legislature for fiscal year 1985-86 began April 1, 1984. Similiarly, April 1, 1985, is the date on which all executive agencies begin preparation of their budget requests for fiscal year 1986-87, which will be submitted to the Legislature in 1986. Dr. Hodes stressed the need for FMA to develop a clear relationship to the budgetary process of state government; for it is the budget and subsequent appropriations act that generate programs affecting the delivery of health care services.

Secretary Pingree and Dr. Howell welcomed the opportunity of input from the new Medical Assistance Panel, which is to consist of the Chairmen of FMA's councils, and which is to be involved at the policy-making level of HRS.

The Council on Medical Economics stated that a definitive action plan needs to be drawn for each of the recommendations passed and approved by the Council. Further, the Council made a specific recommendation that a State Government Calendar, be prepared with key dates identified, such as the April and November budget dates, as well as other governmental key dates identifying activities of interest to FMA. The Council also recommended that the work plans for each approved recommendation also contain trigger dates to initiate action toward implementing those recommendations.

Secretary Pingree stated that the Department of Health and Rehabilitative Services looks forward to increased FMA involvement with HRS, and that periodic dates throughout each year should be set aside for meetings between the Department and FMA. In conclusion, Secretary Pingree and Dr. Howell commended the Council on Medical Economics for the positive steps it has taken, and conveyed to the Council that the door to the Office of the Secretary of HRS is always open to FMA.

Report of the Council on Hospital Medical Staffs

The motion that the report of the Council on Hospital Medical Staffs be filed carried.

Council on Hospital Medical Staffs
Thomas M. Daniel, M.D., Chairman

Pursuant to the direction of the 1984 House of Delegates, the FMA Bylaws were amended to provide for the implementation of the Council on Hospital Medical Staffs. Membership of the Council shall consist of two representatives from each medical district nominated by county medical societies and approved by the FMA Board of Governors. Nominations have been received from the county medical societies, and Council members have been approved by the Board.

Communications have been established with the hospital medical staffs of each hospital in the state regarding the development of the Council and the functions of the AMA/HMSS. In an effort to develop liaison and to address the concerns and issues of mutual benefit, the Chairman of the Council has met with the Florida Hospital Association.

The Council held its first meeting on January 19, 1985. It also sponsored a workshop on Hospital Medical Staffs at the 1985 FMA Leadership Conference. Thomas R. Reardon, M.D., Governing Council of the AMA Hospital Medical Staff, gave an overview of the AMA activities pertaining to hospital medical staffs and an update of current problems hospital medical staffs are facing on a national level.

Two handbooks have been developed, one details the responsibilities of Council members, and the other assists county medical societies in the implementation of local hospital medical staff committees. A quarterly newsletter is also being developed reporting the activities of hospital medical staffs for distribution to hospital medical staffs and county medical societies. Council members strongly recognize the importance of developing a mechanism in which local hospital medical staffs may have effective input. As a result, county medical societies have been encouraged to develop local hospital medical staff committees. The local hospital medical staff committees will help form the communications network necessary to provide input from all hospital medical staffs and will function by communicating bi-directionally with the Council on Hospital Medical Staffs.

The Council recommended the development of a Committee on Risk Management to study the malpractice crisis and to develop an educational program assisting physicians practicing in private or hospital settings with the prevention of malpractice suits.

Recognizing that the membership is currently not totally united, the Council has established addressing these concerns as one of its immediate goals. Several of the long term ongoing goals of the Council include: studying the changing medical care environment and its potential effect on hospital medical staffs and organized medicine; developing services necessary to strengthen hospitals/health facility medical staffs; increasing awareness of issues that are affecting physicians as members of medical staffs; and providing an avenue for hospital medical staffs to have access to the policymaking body of the FMA.

The Council has been very active in its first year of existence and, as a result, has initiated a study on health professionals seeking hospital medical privileges. The Council has assisted the Council on Legislation in studying several major issues and offered assistance to the Committee on PRO in its efforts to monitor PRO activities. These subjects will be carefully studied and the Council's findings will be reported back to the Board of Governors.

The motion of the Reference Committee that the portions of the Report of Florida Medical Foundation — PMUR be filed carried.

The motion of the Reference Committee that the portions of the Report of Florida Medical Foundation — Professional Review Organization of Florida be filed carried.

Mrs. Estelle Dobbins was presented a plaque in memory of her husband, Dr. Burns A. Dobbins by Dr. Frank C. Coleman, FMA President and Dr. Kenneth C. Kiehl, PMUR Chairman.

Report E of the Board of Governors

The motion of the Reference Committee to adopt Report E of the Board of Governors carried.

Recommendation No. E-1 was adopted as presented.

FMA Councils and Committees

COUNCIL ON MEDICAL ECONOMICS

The annual report on the major activities of the Council on Medical Economics is included in this section of the Delegates' Handbook. The Board of Governors has carefully reviewed the activities of the Council during the past Association year and submits the following report and/or recommendations to the House regarding each of the items addressed by the Council.

Freestanding Emergency Centers: The Board approved in principle the FMA working in concert with the University of Florida Center for Health Policy Research in conducting a survey of Freestanding Emergency Centers in Florida.

Standardized Health Claim Form: The Board determined that information regarding the Standardized Health Claim Form be provided to county medical societies for dissemination to their members as they deem appropriate; and further, that the FMA advise the membership regarding changes in the form and revised portion of the narrative through appropriate FMA newsletters and publications; and further, to authorize the distribution of the form and narrative to the membership if Blue Cross and Blue Shield of Florida, Inc. wishes to underwrite the cost thereof.

Workers' Compensation: The Board referred to the Council on Legislation for review the recommendation that the FMA seek repeal of the section of the Workers' Compensation Law that establishes a three-member panel.

Approved and referred to the Council on Legislation for appropriate action the recommendation that FMA seek repeal of that section of the law which mandates that Workers' Compensation reimbursement shall have statewide applicability.

The Board approved the recommendation that the FMA continue to work with the office of Medical Services and the three-member panel in developing testimony to illustrate the need to increase the reimbursement level to an equitable level of the Femur Data Base for 1986.

The Board directed that FMA submit a letter of protest to the three-member panel detailing the dissatisfaction with the small increase in the fee schedule and to reiterate some of the testimony that was presented that clearly indicated the need for a more equitable increase. (Appendix E-1).

Exchange of information: The Board approved the recommendation that the FMA interact with the Office of Technical Assistance, now in the Department of Insurance, to be transferred to the Governor's office by December 1985 for the purpose of exchanging information regarding alternative health delivery systems.

Indigent Care: The Board approved the development of recommendations to submit to the proper governmental authorities to address the issue of adequate health care for the indigent, and further, that the Council be requested to proceed with the recommendation in concert with the Council on Legislation.

Primary Care: The Board urged the Department of Health and Rehabilitative Services that an on-going status report of the DHRS Primary Care Program be provided to the FMA and the following four specialty societies regarding the appropriate designation to areas with significant needs for primary care:

Florida Academy of Family Physicians
The Florida Pediatric Society
The Florida Obstetric and Gynecologic Society
The Florida Society of Internal Medicine

Medicaid Funding: The Board directed that the FMA examine all alternative prepaid Medicaid plans and determine the extent of funding needed to establish such programs for implementation through county medical societies.

Medical Economics Priority: The Board of Governors directed that priority be given to the establishment of a section within the Medical Economics Department to monitor the rapid escalation of alternative health care delivery systems and the impact on the traditional fee for service system of health care delivery; and that this be carried out in the most expedient manner possible within the current staff structure of the FMA.

Physician Contracting Guide: The Board authorized the development of a physician's guide on contracting and negotiating with alternative health care delivery systems in hospital programs, and that this be implemented as part of the activities of the health care delivery system section to be established in the FMA Department of Medical Economics.

Medico Legal Hotline: The Board approved the establishment of a medico legal hotline to assist physicians confronted with potential difficulties and that this program be evaluated in six months to determine the extent of activity and cost benefit rates of the program.

House Committee On Health Care And Insurance: The Board directed that FMA maximize interaction with the Florida House Committee on Health and Insurance, and encourage the Committee to establish dialogue between the major insurance companies and the FMA regarding the financing of health care services and that FMA offer to assist the House Committee in its deliberations on cost containment, cost effectiveness, and quality of care.

Health Care Financing Administration: The Board approved the recommendation that the FMA, as much as possible, interrelate with the Federal Health Care Financing Administration, in addition to the State Office of Technical Assistance and other related State and Federal agencies to provide input in the development of health care financing.

DRGs: The Board approved the recommendation that the Council on Specialty Medicine in concert with FMA's recognized specialty groups document the impact of DRGs on specialty and general practices, and in conjunction with the Subcommittee on Health Care Financing, report to the Board of Governors on a timely basis the impact of DRGs on the practice of medicine.

HMOs: The Board requested county medical societies to provide the FMA with documented instances of quality of care concerns in respect to HMO health care delivery systems. The Board will also study the development of a form to be used to request from county medical societies instances of concern of poor quality of care rendered by health care delivery systems in Florida.

Medical Assistance Panel: The Board approved the establishment of a medical assistance panel to advise HRS through input at the policy-making level; and further, for this panel to enhance the capabilities of FMA staff to serve as a resource in working with HRS staff in providing medical input and assistance in the planning, development, and implementation of health programming.

Peer Review For Fee Disputes: The Board approved the recommendation that the FMA encourage the AMA to seek legislation to modify the current anti-trust laws to permit resumption of peer review for fee disputes.

Relative Value Studies: The Board approved the recommendation that FMA base the 1986 edition of the *Florida Relative Value Studies* on the AMA CPT4 1985 edition.

HMO Accreditation: The Board referred to the Council on Legislation the recommendation that FMA encourage the Department of Insurance to create an HMO accreditation Commission and that if the Department does not accept this recommendation,

FMA's delegation to the American Medical Association prepared itself to attend the upcoming June AMA Annual Meeting in Chicago. Seated (left to right), Luis M. Perez, M.D., Sanford; Charles J. Kahn, M.D., Pensacola; Richard G. Connar, M.D., Tampa; Joseph C. Von Thron, M.D., Cocoa Beach; Charles K. Donegan, M.D., St. Petersburg; Frank C. Coleman, M.D., Tampa; Rufus K. Broadaway, M.D., Miami, AMA Board of Trustees; Sanford A. Mullen, M.D., Jacksonville; Joseph T. Ostroski, M.D., Miami. Standing (left to right): Louis C. Murray, M.D., Orlando; J. Lee Dockery, M.D., Gainesville; T. Byron Thames, M.D., Orlando; Dick L. Van Eldik, M.D., Lake Worth; O. William Davenport, M.D., Miami; Vincent P. Corso, M.D., Miami; Eugene G. Peek Jr., M.D., Ocala; James B. Perry, M.D., Ft. Lauderdale; James W. Walker, M.D., Jacksonville.

then the FMA seek passage in legislation to accomplish the goal. The Board also directed that FMA seek appropriate avenues to assure that quality medical care is provided by all HMOs, including those provided by the HRS prepaid Medicaid plan.

PRO: The FMA House of Delegates at its 1983 meeting adopted Resolution 83-15 and Recommendation No. E-1 of the Council on Medical Economics, which authorized the FMA through the Florida Medical Foundation or other appropriate entity, to apply for designation as a statewide PRO for the state of Florida. Pursuant to the House Action, the Board approved the establishment of the Professional Review Organization of Florida, Inc. (PROF), which was charged with the responsibility of developing the PRO proposal. The PROF Board was comprised of the following physicians:

Charles P. Hayes Jr., M.D., Jacksonville
Daniel L. Seckinger, M.D., Miami
James D. Morgan, M.D., Winter Haven
Charles E. Cernuda, M.D., Tampa
James M. Potter, M.D., Pensacola
John Hackenberg, D.O., Jacksonville
Perry M. Dworkin, D.O., Miami

The FMA owes a tremendous debt of gratitude to these dedicated physicians, along with the FMA staff and a number of highly qualified consultants who spent many weeks developing a lengthy and detailed Request for Proposal (RFP), consisting of two full volumes, which was submitted by the Professional Review Organization of Florida, Inc. (PROF, Inc.) to the Health Care Financing Administration (HCFA) on April 27, 1984. The Technical Proposal consists of 300 pages of narrative in addition to 37 exhibits and 12 appendices. The Business Proposal consists of 10 pages of narrative, five appendices and six exhibits. More than 4364 physicians submitted cards in support of the PROF.

The Statewide Peer Review Organization contract was awarded by the Health Care Financing Administration (HCFA) to the Professional Foundation for Health Care (PFHC), of Tampa, on July 13.. At its meeting on July 18, the FMA Board of Governors directed that FMA submit an immediate letter of protest to the U.S. General Accounting Office regarding HCFA's awarding of the contract to the PFHC and that FMA pursue all administrative and legal remedies available in determining why the proposal of the Professional Review Organization of Florida (PROF), which is a physician-sponsored organization and was supported by the FMA and its component county medical societies, the Florida Osteopathic Medical Association, Florida Hospital Association, Florida Nursing Association and many other allied organizations, was not accepted. All information regarding each of the proposals submitted and the methods of evaluation regarding the award of the contract by HCFA was requested under the Freedom of Information Act in order for the Board to make a determination as to what appropriate action should be taken regarding the awarding of the contract.

The Board at its meeting in October 1984, received a status report on the protest. The Board instructed FMA Legal Counsel, in coordination with the FMA's Washington attorneys, to continue the protest and make every effort to seek an early decision by the General Accounting Office and a reversal of the decision of the Health Care Financing Administration in awarding the contract to the PFHC. The Board further directed that the FMA continue to pursue the lawsuit filed under the Freedom of Information Act for release of all necessary documentation regarding the PRO contract from the Health Care Financing Administration. The Board further directed that the matter of the award of the Florida PRO contract be referred to the American Medical Association and that the AMA be advised of the FMA's deep concerns about the adverse national implications resulting from the manner in which this law is being promulgated by the Health Care Financing Administration, and further, that this information be conveyed in an appropriate resolution to the AMA House of Delegates at its Interim Meeting in December. (Please refer to Board Report C, [blue], Reference Committee III in the Delegates' Handbook.)

A fair hearing was conducted in November 1984, before a hearing officer in Washington D.C., and final briefs were submitted in Federal Court challenging HCFA's refusal to release needed information under the Freedom of Information Act. As of the date of

this report, a ruling on the FMA's protest had not been rendered. An updated report on the PRO will be included in a Supplemental Report to the House of Delegates.

The Board at its meeting in March 1985, directed that the FMA pursue the protest of the PRO award until the results of the fair hearing have been fully determined.

The Board also directed that FMA will continue to monitor the activities of the Professional Foundation for Health Care, Tampa, and continue to collect and evaluate any of the problems FMA members encounter with the PRO.

The Board encouraged county medical societies and recognized specialty groups to participate in the monitoring process of the Professional Foundation for Health Care and report problems to the FMA PRO Committee, and further, that specialty groups be encouraged to provide technical assistance and advice pertaining to their individual specialties to the Committee on PRO.

The Board also requested the Council on Hospital Medical Staffs to monitor the activities of the PRO and report problems to the FMA Committee on PRO.

COUNCIL ON HOSPITAL MEDICAL STAFFS

The Annual Report on the major activities of the Council on Hospital Medical Staffs is included in this section of the Delegates Handbook. The Board has carefully reviewed the activities of this important Council during the past Association year and submits the following report and/or recommendations to the House regarding each of the items addressed by the Council.

Establishment and Charge of Council: In May 1984 the FMA House of Delegates approved a recommendation of the Board of Governors that a Council on Hospital Medical Staffs be established. The Bylaws were amended to include this Council and to give the Council a vote in the House of Delegates.

The decision to establish this Council was made after a review of the complex problems facing medical staffs in Florida and a detailed study of the AMA Council on Hospital Medical Staffs, which was established in 1982. It will provide a forum for addressing the dramatic changes that are occurring in our health care delivery system. There are 217 acute care hospitals in Florida. Of these, 77 are proprietary, 88 are nonprofit, and 52 are government owned. The rapidity of change in Florida is especially dramatic because of the high percentage of Medicare beneficiaries (over 18%), the cost containment efforts of the federal government in Medicare and Medicaid programs and those of business coalitions in the private sector.

The Council is comprised of nine members, two from each of the four medical districts and a chairman appointed by the President. The district members are appointed by the FMA Board of Governors from nominations received from the component county medical societies. Council members must be Florida Medical Association members in good standing. The Council is currently comprised of the following physicians:

Thomas M. Daniel, M.D. Chairman

District A - North Medical District
Richard W. Cunningham, M.D.
William R. Bell Jr., M.D.
District B - West Medical District
Marc Freedman, M.D.
Ray Barnes, M.D.
District C - East Medical District
Leonard Urdman, M.D.
Richard W. Snodgrass, M.D.
District D - South Medical District
Joseph Harris, M.D.
Eno Kaany, M.D.

This Council, as do all other FMA councils, reports to the Board of Governors.

The Council will provide for representation of hospital medical staffs and serve in an advisory capacity to hospital medical staffs throughout the state. At least twice annually, representatives of hospital medical staffs will have the opportunity to meet with the Council to discuss common issues and concerns. The Council will develop and maintain information on issues of common concern to medical staffs and distribute data on successful approaches to problems.

Because of economic pressures brought about by prospective pricing such as DRGs, PROs, HMOs, PPOs and business coalitions for health, hospitals are paying more attention than ever to the make-up of their medical staffs. Many hospitals are keeping a detailed profile of each member of the medical staff. Others are going into joint ventures with members of the medical staff to develop facilities for ambulatory care as a replacement of inpatient care. Other joint ventures may include HMOs, medical office buildings and diagnostic centers.

Some hospitals are looking carefully at the total number of physicians on their medical staff and the specialty mix of these members. Others are developing mechanisms for applying "golden handcuffs" to members of the medical staff, thus binding them tightly to the hospital.

The future economic survival of both the hospitals and the physicians may well depend on a satisfactory working relationship between them. This Council on Hospital Medical Staffs provides a way whereby this relationship can be established.

The major issues to be addressed by this Council include: lack of medical staff voice in hospital planning and in hospital governing board decisions; effect of changes in hospital ownership on medical staffs; competition between hospital ambulatory services and office based practices; hospital diversification into other profit making activities; closed medical staff arrangements and/or exclusive contracts; interpreting and complying with JCAH standards; role of nonphysician health care providers in the hospital; interspecialty jurisdiction in delineation of privileges; and hospital cost containment. The Council has also been charged with the major responsibility of developing a risk management program for physicians serving on the hospital medical staff.

Short and Long-Term Goals

The Board received an update on the formation of the Council on Hospital Medical Staffs and the establishment of short and long-term goals of the Council.

RECOMMENDATION NO. E-1

THAT THE HOUSE OF DELEGATES APPROVE THE ADOPTION OF THE FOLLOWING SHORT-TERM AND LONG-TERM GOALS OF THE COUNCIL ON HOSPITAL MEDICAL STAFFS:

SHORT-TERM GOALS

A. DEVELOP AND STUDY METHODS FOR IMPLEMENTING RISK MANAGEMENT FROM THE POINT OF VIEW OF THE PHYSICIAN AS HE FUNCTIONS AS A MEMBER OF HIS HOSPITAL MEDICAL STAFF.

B. ENCOURAGE THE DEVELOPMENT OF LOCAL COUNTY HOSPITAL MEDICAL STAFF COMMITTEES BY PROVIDING THE SUPPORT AND ASSISTANCE AS NEEDED.

C. STUDY THE EFFECT OF AUXILIARY HEALTH PROFESSIONALS GAINING HOSPITAL PRIVILEGES IN THE PRACTICE OF MEDICINE AS WELL AS THEIR IMPACT ON THE COST OF MEDICAL CARE.

D. ENCOURAGE COUNTY HOSPITAL MEDICAL STAFF COMMITTEES' PARTICIPATION IN THE FMA COUNCIL ON HMS AND THE AMA HMSS.

E. DEVELOP A PROGRAM THAT WOULD IMPROVE THE HOSPITAL MEDICAL STAFF VOICE IN HOSPITAL PLANNING.

F. INFORM THE MEMBERSHIP OF ACTIVITIES OF THE COUNCIL ON A QUARTERLY BASIS IN CONJUNCTION WITH THE BOARD OF GOVERNORS MEETING THROUGH A COUNCIL ON HOSPITAL MEDICAL STAFFS' NEWSLETTER.

LONG-TERM GOALS

A. STUDY THE CHANGING MEDICAL CARE ENVIRONMENT AND ITS POTENTIAL EFFECT ON HOSPITAL MEDICAL STAFFS AND ORGANIZED MEDICINE.
B. DEVELOPMENT OF SERVICES NECESSARY TO STRENGTHEN HOSPITAL/HEALTH FACILITY MEDICAL STAFFS.
C. TO INCREASE AWARENESS OF ISSUES THAT ARE AFFECTING PHYSICIANS AS MEMBERS OF MEDICAL STAFFS.
D. TO PROVIDE AN AVENUE FOR HOSPITAL MEDICAL STAFFS TO HAVE ACCESS TO THE POLICYMAKING BODY OF THE FMA.

Local County Hospital Medical Staffs Committees: The Board encouraged county medical societies to establish local county medical society/hospital medical staff committees composed of elected representatives from medical staffs of all hospitals within the county's jurisdiction.

Local County Hospital Medical Staffs: The Board recommended to county medical societies that each member of the local hospital medical staff committee be an elected member from his/her medical staff serving a two-year term; and further, that he/she be eligible for privileges of the floor in the two Council Hospital Medical Staff statewide meetings held annually.

Slide Presentation: The Board approved the development of a slide presentation for the purpose and development of the Council on Hospital Medical Staffs for use as an educational tool by county medical societies and hospital medical staffs.

Quarterly Newsletter: The Board approved the publication of a quarterly newsletter on Hospital Medical Staffs' activities to be disseminated to county medical societies and local hospital medical staffs.

Risk Management Committee: The Board approved the establishment of a Risk Management Committee under the purview of the Council to identify and develop an educational program to address this issue.

Participation in Statewide Hospital Medical Staff Meetings: The Board approved the recommendation that participation in the Council on Hospital Medical Staffs bi-annual meetings be limited to those delegates who are elected by hospital medical staffs or county chairmen of local hospital medical staff committees who will have the privilege of the floor at these meetings.

Gathered for the presentation of the AMA-ERF checks were the three deans of Florida medical schools. Left to right: Bernard J. Fogel, M.D., University of Miami School of Medicine, Miami; Andor Szentivanyi, M.D., University of South Florida College of Medicine, Tampa; William B. Deal, M.D., University of Florida College of Medicine, Gainesville.

AMA Bylaws Change: The Board approved the recommendation that the FMA pursue through AMA channels an amendment to allow the state chairmen of state hospital medical staff organizations to be delegates in their own right to the AMA Hospital Medical Staff Section.

RESOLUTION 85-2
Alternative Delivery Systems
Duval County Medical Society

The motion of the Reference Committee to refer Resolution 85-2 to the Board of Governors carried.

RESOLUTION 85-2

Alternative Delivery Systems

(Referred to Board of Governors)

Whereas, Tremendous emphasis is being placed on alternative delivery systems by government and business leaders; and

Whereas, An increasing number of patients are becoming confused as to what these alternative systems will do for them; and

Whereas, The traditional patient-personal physician relationship is being seriously eroded; and

Whereas, The Florida Medical Association membership needs to be kept informed regarding these systems and how it can effectively compete against them; therefore be it

RESOLVED, That the Florida Medical Association place more emphasis on providing information to its membership regarding alternative health delivery systems and develop a strategy and plan of action that can be used by physicians individually or collectively in competing with said systems; and be it further

RESOLVED, That funding and staffing be added to bring this program into fruition as soon as possible.

RESOLUTION 85-4
Workers' Compensation Medical Fee Schedule
Dade County Medical Association

A Substitute Resolution 85-4 was offered by the Reference Committee and its adoption moved. The motion carried and Substitute Resolution 85-4 was adopted.

SUBSTITUTE RESOLUTION 85-4
Workers' Compensation Medical Fee Schedule

RESOLVED, That legislation revising the workers' compensation reimbursement system be sponsored by FMA and be given a high priority; and be it further

RESOLVED, That the FMA immediately retain expert legal counsel knowledgeable about the workers' compensation laws, for purposes of legal or other actions against the appropriate party or parties to accomplish the goals of Resolution 83-7; and be it further

RESOLVED, That all county medical societies be informed of the progress and status of this situation on a timely basis.

RESOLUTION 85-6
1986 Relative Value Study
Dade County Medical Association

Upon recommendation of the Reference Committee, Resolution 85-6 was not adopted.

RESOLUTION 85-22
Competition in Medicine
Palm Beach County Medical Society

A Substitute Resolution 85-22 was offered by the Reference Committee and its adoption was moved. The motion carried and Substitute Resolution 85-22 was adopted.

SUBSTITUTE RESOLUTION 85-22
Competition in Medicine

RESOLVED, That the Florida Medical Association's AMA Delegation submit a resolution to the American Medical Association urging the Congress and the President to end the mandate requiring employers to offer an HMO system, and be it further

RESOLVED, That the Florida Medical Association urge the Florida Congressional Delegation to also seek an end to the mandate requiring employers to offer an HMO option.

The Reference Committee expressed gratitude to all FMA members and staff who appeared before the Committee.

The Reference Committee Chairman expressed that he was fortunate to work with a most efficient and informed Committee, John M. Canakaris, M.D., Robert L. Dawson, M.D., Alan J. Yesner, M.D., Charles B. McIntosh, M.D., Miguel Figueroa, M.D., Ralph E. Rydell, M.D., Jack W. MacDonald, M.D, and AMA Delegate Joseph C. Von Thron, M.D., AMA Alternate Delegate Dick L. Van Eldik, M.D., and also expressed his appreciation to Richard S. Hodes, M.D., Chairman of the Council on Medical Economics and T.M. "Dan" Daniel, M.D., Chairman of the Council on Hospital Medical Staffs for their outstanding effort on behalf of FMA members this past year.

The Reference Committee also thanked Mrs. Lynn Mobarak, Mr. E. Russell Jackson, and Mr. Robert W. Seligson for their able assistance in the preparation of the report.

The motion of the Reference Committee that the Report of the Reference Committee No. V, Medical Economics, be adopted as amended carried.

The 1985-86 Florida Medical Association Board of Governors poses for the first time after the final session of the House of Delegates. Seated (left to right): Past President J. Lee Dockery, M.D., Gainesville; President-Elect James B. Perry, M.D., Ft. Lauderdale; Treasurer Yank D. Coble Jr., M.D., Jacksonville; Vice President James G. White, M.D., Ormond Beach; President and Chairman Luis M. Perez, M.D., Sanford; Immediate Past President Frank C. Coleman, M.D., Tampa; Secretary Henry M. Yonge, M.D., Pensacola. Standing (left to right): Donald C. Jones, FMA Executive Director; Speaker of the House Guy T. Selander, M.D., Jacksonville; Kay K. Hanley, M.D., Clearwater; Robert N. Webster, M.D., Tallahassee; Charles K. Donegan, M.D., St. Petersburg; Charles B. McIntosh, M.D., Jacksonville; Gerold L. Schiebler, M.D., Gainesville; Dick L. Van Eldik, M.D., Lake Worth; A. Frederick Schild, M.D., Miami; Miss Jane A. Daniel, Student Member; Eugene G. Peek Jr., M.D., Ocala.

FMA President Frank C. Coleman, M.D., received recognition from the Florida Society of Pathologists. Dr. Glenn S. Hooper, Florida Society of Pathologists President, presents a plaque.

Dr. Perry then recognized Dr. Glenn S. Hooper, President of the Florida Society of Pathologists, who requested the privilege to speak to the House. Dr. Hooper presented from the lecturn to Dr. Coleman an expression of recognition for Dr. Coleman's outstanding service as President of the Florida Medical Association on behalf of the Florida Society of Pathologists.

Dr. Perry then recognized Dr. Perez who announced the members of the Board of Governors who had been either appointed or elected:

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A. Frederick Schild, M.D., D-88
Robert N. Webster, M.D., SBME-86
Eugene G. Peek Jr., M.D., HRS-86
Miss Jane A. Daniel, Student Member (UM)

The appointments of Council chairmen were also announced:

Judicial Council — Joseph H. Davis, M.D.
Council on Legislation — Louis C. Murray, M.D.
Council on Medical Services — Joseph T. Ostroski, M.D.
Council on Scientific Activities — Pierre J. Bouis Jr., M.D.
Council on Specialty Medicine — William T. Hawkins, M.D.
Council on Hospital Medical Staffs — T.M. "Dan" Daniel, M.D.
Council on Medical Economics — Richard S. Hodes, M.D., and Charles P. Hayes, M.D., Co-Chairmen

Dr. Perry then called Dr. Alvin E. Smith to the podium for the benediction

The 1985 House of Delegates adjourned at 11:20 a.m.

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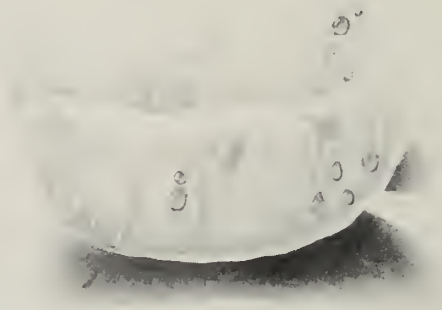
Foods related to lowering the risk of cancer of the larynx and esophagus all have high amounts of carotene, a form of Vitamin A which is in cantaloupes, peaches, broccoli, spinach, all dark green leafy vegetables, sweet potatoes, carrots, pumpkin, winter squash and tomatoes, citrus fruits and brussels sprouts.

Foods that may help reduce the risk of gastrointestinal and respiratory tract cancer are cabbage, broccoli, brussels sprouts, kohlrabi, cauliflower.

Fruits, vegetables, and whole-grain cereals such as oatmeal, bran and wheat may help lower the risk of colorectal cancer.

Foods high in fats, salt- or nitrite-cured foods like ham, and



fish and types of sausages smoked by traditional methods should be eaten in moderation.

Be moderate in consumption of alcohol also.

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Weight reduction may lower cancer risk. Our 12-year study of nearly a million Americans uncovered high cancer risks particularly among people 40% or more overweight.

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Indigent care: salvage the system or continue its carnage?

Twenty years after the Medicaid Act in 1965 yanked the responsibility of indigent care from the province of local physicians, community institutions, and volunteer groups, the government has reneged on its commitment and pruned its responsibility for health care for the poor. Within a short period of 90 days, the DRG system and federal cuts in Medicaid were proposed and imposed. The health care system had no time to evaluate or respond to such abrupt changes, and these alterations in reimbursment have forced many hospitals to restrict their indigent care. The stories we read about destitute patients being shifted from hospital to hospital where they are not wanted remind me of the wretches painted so dramatically in Gericault's "The Raft of the 'Medusa'"[1]. The medical indigent care system is about as desperate as the adrift individuals depicted on that raft.

The number of medically impecunious in the United States is immense and expanding: 35 million people lack health insurance of any type (an increase of 10 million since 1977) and another 22 million are enrolled in Medicaid. Medicaid patients in most states are not included among these uninsured figures, but the stingy Medicaid reimbursement schedule in Florida certainly consigns them to indigent status. Children constitute 46% of poor Americans and fewer than one third of them have any type of health insurance. The elderly, particularly those who cannot afford the increases in Medicare deductions, comprise 10-20% of our impoverished. In all, approximately one fourth of the nation's population is medically indigent.

We as physicians can approach the indigent problem several perspectives and have the following options: (I) We can ignore it; (II) We can besiege and beseech the legislatures to increase funding; (III) We can establish different tiers of health care delivery and relegate the indigent to a level of care less demanding on the physicians; or (IV) We can assume full responsibility and devise alternate, pluralistic approaches to the problem. I would like to explore these alternatives.

Option I: ignoring the problem • We can ignore it, continue business as usual, and hope that the problem will spontaneously resolve. Acceptance of this option is irrational for ethical, economic and political reasons.

Ethically, physicians have always committed their services to all who require them; repudiation of that obligation after 25 centuries is repugnant. Fortunately, most physicians — about 80% of the total — provide some free care.

Economically, the restriction of access by the poor to medical care today will increase society's cost for their care tomorrow. Lack of insurance in 1983 dissuaded 5 million patients from acquiring medical care and treatment. Investigations examining the ultimate price of such medical deprivation have been conducted. Several have demonstrated that one dollar's worth of prenatal care can save two to eleven dollars of services required by those infants of mothers who were denied prenatal care. Additionally, inadequate prenatal care leads to low birth weights, and children with low birth weights experience increased rates of neurologic and mental defects which may result in conditions that ultimately will have to be funded by society.

Current privation mandates future satiation. Recent studies hint at the magnitude of the future cost. One explored the consumption of services by

	1985	1995
Total Health Resources	$1.00	$1.00
Physician Share	.25*	.20*
Indigent Care	.15	.20
Other	.60	.60

Physician Loss (1985-1995) = $0.05 ÷ Physician Share (1985) = $0.25

5¢/25¢ = 20% Loss By Doctors

Medicaid patients immediately after enrolling them into an HMO. First-year usage of medical resources was 550% higher for the Medicaid than for the non-Medicaid enrollees! Another study examined the effects on hypertensive patients of California's Medi-Cal cutbacks in 1982. One year following the cutbacks, the average diastolic blood pressure of disenfranchised hypertensives increased by 10 mm HG — an increment known to significantly increase the incidence of stroke, heart disease and renal failure. The final bill to society for these complications remains speculative but obviously will be enormous.

Physicians cannot afford to ignore the medical requirements of one quarter of our population. The totality of medical reserves is finite; if the flow of resources drained by the poor accelerates, the remaining resources available for physician fees and other services must shrink.

Let us examine the following scenario: Assume that the total health resource pool is fixed in 1985 dollars and that all other demands on health care, excluding the poor, are stable. Assume also that failure today to provide preventive health care for the poor increases their total proportion of the health budget by an additional 5% in 1995. If the total amount of resources is constant, where is the extra 5% of cost to be derived? Probably from physician fees. Physician fees currently consume about 25% of the total health budget. If we surrender 5% of the total health care dollar, our actual loss in real wages is 20%. Economic preservation, if nothing else, should motivate each physician to participate in the resolution of the health care crisis for the indigent.

Politically, it is imperative for physicians to wrestle with and prevail over the problems of indigent care. Our leadership role in health care policy has steadily eroded since Medicaid and Medicare were enacted in 1965. Government now realizes that it can no longer efficiently and economically provide medical care for such a large share of the population. Government is temporarily weary of the battle and, in a gesture of exhaustion, has retreated from its obligations to health care. If organized medicine can opportunistically use government's current policy of confusion and retreat to imaginatively and forcefully provide solutions to indigent care problems, we may be able to recapture our primacy over medicine. Conversely, if we abandon care of the medically indigent, doctors as a group will sacrifice the remaining respect and prestige they enjoy within society. Such a loss of esteem will deprive the profession of the small residual political leverage it savors. Thus, ethical, economic and political concerns mandate that we embrace as our own the problem of the medically indigent.

Option II: seeking increased government funding: • This option entails lobbying government on all levels for greater financial support for medical care and should be rejected immediately. It is untimely because federal and state governments are interested in truncating, not enlarging, their budgetary social commitment. It is hypocritical because organized medicine has traditionally resisted governmental meddling in day-to-day patient care. It is threatening to the physician's freedom because of increased government regulation.

Option III: continued stratifying of health care delivery • This option is perhaps more reasonable. Historically the majority of indigent care has always been assumed by a limited number of institutions. In cities the house staff and faculty of inner city volunteer teaching hospitals, and the staffs of other public hospitals, have provided 75-80% of indigent care. County hospitals and health clinics have provided indigent care in rural and suburban regions. County hospitals and health clinics, however, commonly provide only acute care and preventive medicine since frequently they are not equipped with the technology and house staff of the teaching institutions and do not provide the same degree of sophisticated care such as kidney dialysis, transplant programs and cardiac surgery.

DRGs and cuts in Medicaid have depleted the financial reservoirs of most indigent care hospitals. These institutions are surviving by deficit funding and teetering on bankruptcy. Their financial plight is not due to inefficiency or poor management; it is due to lack of revenue. Some hospitals pay for indigent care by shifting the expense to private patients. As indigent care institutions fill their beds with the poor, their private patient census has declined. Further cost shifting to private-pay patients is no longer possible. Recently bloated demands on their services have been perpetrated by the practice of "dumping" economically high risk, uninsured patients from for-profit hospitals to public hospitals. Hospitals com-

mitted to serving the poor cannot continue to absorb more unfunded care, even though the indigent ranks are burgeoning. Private medicine must divert some of the pressure from this indigent care system or it may collapse. If it fails, the government will be forced to substitute the wreckage with a hastily-built system which will be far less desirable than what we now have.

How can we optimize physician participation? •

(a) Streamline Overhead. A low overhead system that minimizes time involvement can be structured. It might be advantageous for doctors to work for the indigent during hours they presently do not work and at places other than in their own offices. Indigent clinics which employ volunteer workers can provide the most cost-effective means of seeing such patients. The Florida Arthritis Foundation has done this for years. The Foundation pays no money for the care of indigents but recruits volunteers to work in, schedule and coordinate their clinics. It also trains volunteers not only to educate patients about their disease but to teach them how to exercise and adapt their activities of daily living. This use of a volunteer workforce limits the expense of providing services. For instance, personnel costs for most private rheumatologists vary from $30-$60/hour. A 15-minute office visit with an indigent patient, therefore, consumes $7.50-$15 of personnel overhead alone. In a clinic manned wholly by a volunteer workforce, this overhead expense is reduced to zero. We should extend this type of volunteer participation in indigent care to other community service organizations. Time donated by lay people can diminish the financial burden imposed on the physicians who accept indigent care responsibility and hopefully would encourage more physicians to participate in such a system if the burden of care was disseminated fairly among professionals.

(b) Increase Productivity With Paramedics Physicians can expand their roles by overseeing clinics in which physician's assistants and nurse practitioners operate. These paramedical individuals can examine and educate patients, record data and dictate the doctor's decisions regarding diagnosis and treatment for transciption into the chart. Such personnel can increase physician productivity and reduce physician time in providing a service, particularly in the areas of pediatrics, family practice, internal medicine and prenatal care.

(c) Ration Services. Perhaps some types of care for the poor will have to be rationed. If the system has only "X" amount of dollars for indigent care, does it make sense to consume as many dollars to replace a hip joint in a 75-year-old arthritic as it takes to treat 10 hypertensives for one year? I think not, particularly when lack of hypertension treatment may generate a future demand on the dollar reserves of the system that can be 10 times more costly than the original hip surgery. On the other hand, joint arthroplasty would be indicated for an individual with a high likelihood of returning to work and escaping his indigent status.

We should develop criteria for the use of expensive, high technology practices such as intensive care for the terminally ill. The health economist, Eli Ginzberg, recently commented that, "Medical care is not that expensive; it is dying care that must be restrained." Economic as well as scientific and ethical considerations will have to be factored into our judgment algorithms.

Care also may have to be rationed to the non-compliant and irresponsible. The reasons for non-compliance, of course, should be weighed individually but patients must be impressed with their responsibilities to the system. If they waste scarce resources, they effectively deny services to other worthy, needy individuals.

The concepts of rationing and stratifying health care may scarify the ethical instincts of many physicians. The realities, however, are that all societal needs including housing, education and food are rationed or stratified by economic considerations. Financial criteria assign people to the level of care they will receive. Planned, rational entry into the health care system based upon economics is not ideal but certainly surpasses the current health care system which is haphazard, unstandardized and accelerating toward annihilation. Total access has been curtailed by government with no thought given to the long-term costs of such cutback in funds. It seems more logical to exclude or limit certain high cost types of care and procedures where long-term economic benefits are questionable but not reduce all care, including that which is economically sensible.

Option IV: devising alternate approaches • The fourth option is to formulate multiple plans tailored to an individual community. The scope and resources for indigent care in Miami differ from those in Daytona Beach or Pensacola. A national or statewide system cannot mesh with such distinctive, parochial requirements. County medical societies should initiate the design of more comprehensive local programs and enlist the cooperation and input of the health department, all hospitals (including the proprietary, public and volunteer hospitals) and all

volunteer and other health care provider groups. The size of the local indigent population needs to be assessed and their health needs profiled. Both current and future total community resources derived from insurance, Medicaid, taxes, philanthropy and volunteer agencies should be measured. Allocation of all resources must be prioritized according to long-term economic, medical and educational goals of the community. Perhaps different professional fee schedules will have to be constructed based upon physician cost of indigent care. For instance, the obstetrician who delivers an indigent mother may be entitled to a higher fee because of his higher malpractice risk than a surgeon who performs a procedure requiring similar skill but less malpractice risk. After its design, public input could be invited and modifications inserted. All physicians should be encouraged to participate in such community-wide progams.

After implementation of a local system, continuous documentation and periodic analysis of its results should be gathered and presented so that comparisons of results among different locales can be made and flexibility, adaptability and upgrading can be secured. The system design will be laborious and require enormous volunteer work on the part of physicians and other health care workers. These concepts will discourage many; however, providing our own system can avoid further government seizure of our professional privileges and freedom. I see no other choice.

Florida has recently provided the impetus for such programs. As of July 1, funds for indigent care were granted to local county health departments for distribution. Perhaps we can use this state initiative as a nidus upon which to crystallize a more comprehensive system.

The gauntlet of care for America's displaced indigents has been cast at the feet of organized medicine. If we accept the challenge and provide the imagination, energy and organizational skills necessary to partially or wholly resolve the problem, society will perhaps allow us to re-establish our credentials as appropriate caretakers of the public's medical welfare and restore to us our lost leadership in American medicine. We in Florida have an opportunity to lead the nation in responding to these issues. I would hope that the FMA will harness the forces necessary to do so.

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Jacques R. Caldwell, M.D.
Daytona Beach

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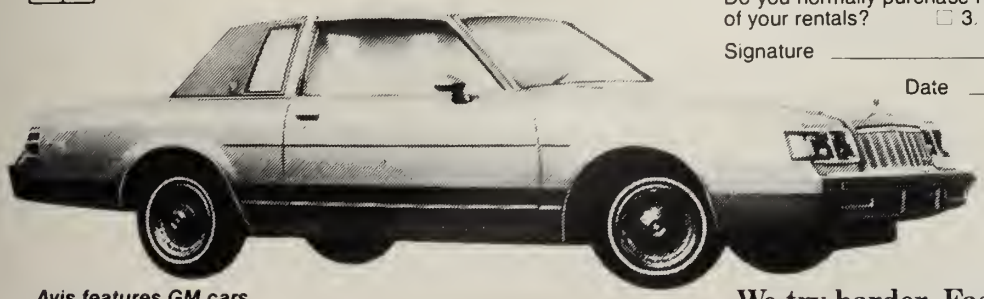

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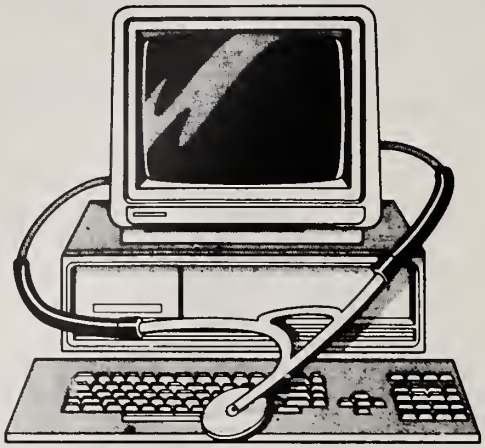

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NOTES & NEWS

Dr. Prather appointed State Epidemiologist

Dr. Prather

Luis M. Perez, M.D., President of the FMA, recently wrote David H. Pingree, Secretary of the Department of Health and Rehabilitative Services (HRS), endorsing his appointment of E. Charlton Prather, M.D., M.P.H., as State Epidemiologist, to become effective October 14, 1985. Dr. Prather who is currently serving as the Health Program Supervisor for District II of HRS, is a nationally recognized expert on epidemiology and communicable disease control. He was originally named State Epidemiologist by the old State Board of Health in 1960, a position Dr. Prather held until July of 1974. He will reassume this position in October of 1985.

The establishment of the position of State Epidemiologist was approved by the Legislature in the 1985 Appropriations Act. Governor Graham included the position in his budgetary request to the Legislature, which was a positive response to a resolution by the House of Delegates approved at the 1985 Annual Meeting resolving that the position of State Epidemiologist be re-established.

Dr. Prather was Florida's State Health Officer as Director of the Division of Health and, after the reorganization of HRS, Staff Director of the Health Program Office from 1975 to 1979. He received his Doctor of Medicine degree from the Bowman Gray Medical School, Wake Forest, and his Master of Public Health degree in Epidemiology from the University of North Carolina at Chapel Hill.

As a member of the Florida Medical Association since 1959, Dr. Prather has fully participated in the activities of the FMA and its component specialty and county medical societies.

He has served on the FMA Council on Specialty Medicine continously since 1965. He is a Past President of the Clay County Medical Society and is currently a member of the Capital Medical Society. Dr. Prather was also the President of the Florida Society of Preventive Medicine.

Born in Jasper, Hamilton County, Florida, Dr. Prather is truly a Floridian. Dr. Prather has well served the public health needs of Florida's entire population. He continues to be an invaluable member of the medical profession and brings to the position of State Epidemiologist the full support of the FMA.

Dr. Feinstein steps down as editor of Miami Medicine

Richard J. Feinstein, M.D., has resigned as Editor of *Miami Medicine* after five highly successful years. During his tenure, he contributed 54 editorials and won several awards in *The Journal of the Florida Medical Association* Annual County Medical Bulletin Awards Contest. He has recently been named a Contributing Editor of *The Journal of the Florida Medical Association*.

Dr. Feinstein serves as Associate Clinical Professor of the Department of Dermatology at the University of Miami School of Medicine. A graduate of the State University of New York College of Medicine, he did his internship at Georgetown University Medical Division, District of Columbia General Hospital. He did his residency in dermatology at the University of Miami School of Medicine and Jackson Memorial Hospital.

Dr. Feinstein is actively involved in many professional organizations such as the Florida Dermatology Society, American Academy of Dermatology, and the Florida State Board of Medical Examiners.

In addition to serving as Editor of *Miami Medicine*, he currently is the only physician member of the Board of Contributors on *The Miami Herald* newspaper and he is the Editor for the Florida State Board of Medical Examiners' Newsletter.

Workshop on Marketing Strategies for Private Practice

A workshop on "Marketing Strategies for Private Practice" will be held on Saturday, September 7, in Kissimmee, Florida. Sponsored by The Florida State Society of Medical Assistants, it will be conducted by

Barbara Gore, Program Director of the Department of Practice Management of the American Medical Association.

The workshop will focus on specific, practical techniques that can be used to develop a coordinated marketing plan for a physician's office, enhance patient satisfaction, and maximize the efficiency of existing office procedures. The program will include several topics of discussion, including the "Doctor Surplus", the marketing process and marketing research, maximizing patient satisfaction, pricing physician services and increasing practice visibility. Each participant receives a copy of "Marketing Strategies for Private Practice"SM workbook, which conforms to the format of the workshop.

Application has been made for Continuing Medical Education credits for physicians and medical students. The deadline for registration is August 23, and prompt registration is urged as the number of participants in limited. The workshop, to be held at the Hilton Inn Gateway in Kissimmee, begins at 9:00 a.m. and ends at 5:00 p.m., with registration from 8:30 to 9:00 a.m. Hotel reservations are to be made directly with the Hilton Inn Gateway at (305) 396-4400.

DEAN'S MESSAGE

Preventive Medicine

It has not been so terribly long since each practicing physician was expected to be as adept a counselor for both the community and the individual with regard to public health as he was a practitioner of illness care. Public health practice as it pertains to the community has now evolved into an independent specialty that meets even the strictest definition of specialty practice. Graduate training in Public Health is through a residency program with several tracks including not only public health administration, but also preventive medicine, aerospace medicine and occupational health. There are well established certifying boards. Public health practice is at least as demanding as any of the other medical specialties.

What public health as currently practiced cannot do, largely for mechanical reasons since it is community oriented, is offer individual consultative advice patient by patient on matters of personal preventive medicine and health care.

Preventive health care is no less essential than illness care; however, the public and our profession alike have been slow to acknowledge that indeed it has real value. Prospective preventive medicine has always been taught to be an integral component of illness care. An appreciation of the value, not just the common sense value but the dollars and cents value, of preventive medicine when offered before the fact rather than after the illness has been a quiet revolution in health care. If preventive medicine is successful, the result is continued good health, which most of us hope to enjoy in any case, and as a product it is difficult to both document or sell.

There is a world of nonphysicians selling good health maintenance advice and legions of hucksters offering advice which is at best questionable and occasionally harmful to more than one's pocketbook. The line between good health habits and prescriptive health maintenance often is subtle. There are many patients for whom the simplest health advice should be tempered by a comprehensive knowledge of their medical history. In the foreseeable future, preventive medicine will remain an inseparable component of each physician's practice of medicine and an essential component of the undergraduate, graduate and postgraduate medical curricula.

William A. Sodeman Jr., M.D.
Deputy Dean for Academic Affairs
University of South Florida
College of Medicine

ENCORES!

Renaissance of medical humanism

The Council of Medical Education of the American Medical Association has noted the need to reemphasize the desirability for potential physicians to obtain a cultural education in order for them to be humanistic and sensitive to patients from varying backgrounds.

That the humanities provide important preparation for medical education is a dogma little disputed by medical educators. The humanities are expected not to intrude into classroom discussion or take precious time from technical studies in medical schools. Medical educators expect their students to bring a "liberal" education with them.

Patients and physicians are in an essentially personal interaction which depends upon a proper balance between scientific and humanistic thinking. Yet humanistic skills are neglected in medical education today. The humanities have suffered dilution in the pre-medical years since the nineteen forties.

Patients and public agencies are becoming more vocal about what they describe as an insensitivity to values in medical affairs. They use words like "dehumanization," "humiliation," insensitivity," and other derogative adjectives to describe the experiences of patients in America.

Humanism can best be defined as the philosophy which recognizes the value or dignity of man. It makes man the measure of all things. The term "humanism" is derived from "humanitas" which at the time of Cicero meant the education of man by the liberal arts, instruments which disciplined man properly to differentiate him from other animals.

America needs to train humanistic physicians. We must not minimize or supress humanism in medical education. Reorientation toward the history and culture of antiquity can effect a reorientation towards a more human future for the medical profession.

The cultured physician of the past possessed an ideal order of knowledge and being. The whole of reality, social, political, economic and intellectual was in principle, a hierarchical system of clearly defined minute subordination and superordination.

We must not overlook the old curriculum based on grammar, rhetoric, history and moral philosophy. The dignity of man in the technological society requires the literary and scholarly knowledge of the classical past. A study of the classical past in a comprehensive sense of the word would develop the kind of sensitive intuition and subtle powers of judgement that will permit physicians to advise and to act wisely amid the complexities of the ever increasing dehumanized technological society.

A more humanistic physician would be able to handle better the mass of complexities, ambiguities and imponderables he meets in the practice of medicine. Many of today's physicians are unprepared by their medical education to examine and deal with the questions of sensitivity of patients' values in our technological society.

In the Western World we talk about the educated man and frequently identify him with the cultured man. But an educated man like a physician is not necessarily a cultured man. The cultured physician is not the merely knowledgeable person, but the person who is knowledgeable and uses his knowledge humanely.

The cultured physician is an artist, an artist in humanity. His art consists, in part, in the ability and the skill with which he wields the tools of knowledge and experience. The cultured physician believes that the only philosophically tenable position even for a pessimist in these days is optimism. He knows that compassionate understanding and sympathy is the approach of the humane, while blame and censoriousness is the approach of the insufficiently humane.

Physicians are beset on all sides by a host of problems that are on the verge of destroying free medicine in America. The hopes and fears which pervade the modern medical society rest on the moral fiber of the physician, and on the wisdom and responsibility of those who promote the course of its development.

Doctors are at a crossroads: one road to an almost dehumanized medical society run by the government with the physician as a helpless cog in a machine; the other to a renaissance of humanism to a free medical society dedicated to the service of man's well being.

Edward Pedrero Jr., M.D.
Tampa

Reprinted with permission from *Hillsborough County Medical Association Bulletin*, May 1985, Vol. 31, No. 1.

Do we have any choices?

This article began several months ago, on the floors of Fish Memorial Hospital, as I was lamenting no, complaining about one of the more recent decisions forced upon me by the hospital reimbursement policies of the PRO. A patient undergoing a pacemaker insertion, and subsequently, a hernia repair, required two separate hospitalizations, so as not to incur a DRG loss for the hospital. In addition, the patient had to endure an additional ten days of discomfort, while awaiting his hernia repair. The logical and more cost effective approach would have been to repair the hernia while he was recovering from the pacemaker insertion.

The absurdity of all this was exasperating. I thought, "Can't something be done about this?" I have written a letter to HCFA, in hopes of enlightening them.

The whole episode, however, exemplifies the most crucial problem facing physicians today. We are losing control over the decisions regarding patient care. Extending this even further, we are losing control over many decisions affecting the medical profession.

Under the banner of "Quality health care and cost containment," great changes are sweeping the health care industry. Some of these changes are overdue, but others threaten to complicate and even hinder the delivery of quality care.

Medicine as we know it today is under siege. Government regulations and DRGs have caused economic concern. The malpractice insurance crisis looms constantly over our heads, forcing us to practice defensive, and at times, cost-ineffective medicine. HMOs, PPOs, Networks, and the like threaten to swallow us all, endangering the existence of the private practitioner.

Superimposed upon all this is a much more intelligent, informed and demanding consumer public than ever before. Through rhetoric, political action and legislation, the bureaucrats have converted physicians into a mere parcel of the health care product. Physicians are not accustomed to being viewed in such terms. After all, we are professionals. We serve our patients, not customers. We are engaged in the practice of medicine, not business. Ethical and sociopolitical considerations notwithstanding, the major forces of change relate to economics.

Any observer outside of the medical profession might easily conclude that organized medicine is self-serving, protecting doctors' pocketbooks. Obviously, that is a gross oversimplification. Of course, we are concerned about our financial futures. So is every other segment of our economic society: laborers to lawyers, accountants to airline pilots, and so on. We need not feel guilty about that. In the context of our economic society, we work hard, and should enjoy the fruits of our labors, both in the personal satisfaction of helping our patients, as well as enjoying a high standard of living.

It would be grossly unfair to state that our only concerns are our personal fortunes. Above all, we are the patients' advocates. Physicians, not administrators or bureaucrats, still know what is best for patients. The ultimate responsibility for patient care decisions must remain in the hands of physicians.

To summarize: the government, lawyers, corporations and the public expect the very best health care at the cheapest prices and demand that we bear the full burden of responsibility. In product lingo — they want the quality of an expensive automobile, complete with all guarantees, for the price of an economy car.

The changes occurring in health care have been inevitable. Certainly, the medical professional has resisted changes, not always constructively. Our political efforts in that regard have often been perceived by the public as being self-serving. Perhaps our obstinacy and lack of political savvy have militated against us. Perhaps we simply have not done a good enough job at public relations.

The purpose of this article is not to find fault with the past, but to engender positive constructive action in the future, starting now. I do not intend to dispense a solution for the problems facing us. In broad conceptual terms, however, I would like to offer some thoughts, starting with the most basic of questions asked us: "Why do you want to be a doctor?" I dare say the answers would include the concepts of helping our fellow man, engaging in an intellectually satisfying endeavor, enjoying economic security, and exercising some control over our destiny. Placing these goals in the context of our present problems, the key word is control, a euphemism for power. Who will have the power? Do we have a choice?

It goes without saying that the patient is the "star" in this show. It is the patient who must be the recipient of our greatest ideals and skills. Unfortunately, the government, hospital corporations, hospitals, insurance companies and yes, even physicians, (though we have been the last to realize it) are locked in a power struggle for control! All this thanks to the ugly word — Economics. What most do not understand is the patient's primacy in the grand scheme of things. He is caught in the middle.

From the standpoint of physicians, we are experiencing less control over therapeutic decision making. Our economic security is threatened and our ability to control our destiny is uncertain. This is just cause for concern.

What can be done? First of all, we must come to grips with reality. The service we render is a product. Health care delivery is big business, and we are part of it, like it or not. If we don't run the business properly, someone else will. I would also like to dispel the view that there is no problem. Many say, "So what! We'll just live with it, adjust, make do, it won't be so bad." Observations of other countries' systems bespeak the contrary.

Many physicians work for large groups or corporations and are perfectly content. I do not condemn that. Large numbers of graduates from medical schools and training programs have not experienced the practice of medicine as we know it. They may want no part of economics or politics. These groups may not experience a problem now, but as economic forces come to bear on all of us in the future, they may ask, "where did we lose control?" Some would say it is too late, nothing can be done. Perhaps so, no one knows. It is certain that "nothing ventured, nothing gained." History is replete with examples of societies failing to see the handwriting on the wall, only to crumble. A defeatist attitude, burying our heads in the sand, hoping everything will be acceptable, will eventuate in defeat for us and our patients. Some would advise the formation of a physician's union, a physician-owned insurance company or other such entities. I am certainly not in control

of the data required to advise any one specific course.

Common sense, however, demands one overwhelming alternative; that is action — not just knee-jerk reaction. We can be part of the changes. We can mold them. We can look inside ourselves, look at the needs of our fellow-man, and promote policies that show we are receptive to peoples' needs. Organized medicine can be the vanguard of imaginative legislation. We will have to make compromises to maintain our credibility. Nothing stays the same forever.

All of this takes work. It means attending meetings, writing letters, becoming politically informed and active. It means hard work in salesmanship and public relations, starting with our own offices, cultivating rapport with our patients and the community at large. We must be able to prove to the public that the concerns of the patient and concerns of the physician are not mutually exclusive.

We cannot afford to isolate ourselves within our individual practices. Of course, differences of opinion exist between members of individual hospital staffs, so even greater differences might be expected between the various areas within a county and certainly between the various areas within a county and certainly between county medical societies. Furthermore, it is understandable that our differences are not just petty. We must work together, however, to attack the issues and problems which transcend our individual preferences. We must define the goals which are common to us all and work to achieve them.

I have not said anything new. All of you know what is happening. I am making a plea, if you will, for unity and action. The trite phrase, though often used, is no less applicable — "United we stand, divided we fall."

Avrohm Faber, M.D.
New Smyrna Beach

Reprinted with permission from *The Stethoscope*, Summer Issue, 1985.

What can doctors do when a colleague is incompetent?

There's an isolation notice on the hospital room door. Inside, the silence is violated by the ragged, agonal breathing of a 55-year-old man I've known for a year. The staff doctors tell me he's sunk into a coma, ravaged by an infected brain, paralyzed on one side and unable to talk. He has AIDS.

I stand at his bedside. His head is skewed to one side, his breaths are rapid and rasping and his face is pale and soaked with sweat. Expecting no response, I say his name. But he opens his eyes and looks at me, an intelligent look. One brow goes up.

The look tears through me like a knife. A few minutes later, I creep out of the room, feeling like the worst doctor ever created. It's not that we are not giving him every appropriate medicine. It's not even knowing that we cannot cure AIDS. But when I see intelligent awareness in the midst of the pain of that ravaged body, I cannot bear not being able to relieve it.

I want to be a "good" doctor, and "good" doctors relieve suffering. I want desperately to be able to give him enough narcotics to stop his suffering — whether that pain is physical or simply the agony of not knowing whether you will be able to manage another breath.

Of course, that much narcotics might also end his life, and "good" doctors are not supposed to kill.

Furthermore, I do not know that he would wish it of me — and he cannot say.

His family and I have decided that we will not interfere when he stops breathing, but now, all I can do is shift his pillow, touch his shoulder, check the medications, wonder how long this can go on — and feel like a very bad doctor.

People in and out of medicine have very definite ideas about what makes a bad doctor. Some, incompetent because of alcohol or drug abuse, injure or kill their patients. Others are sufficiently unscrupulous to deliberately perform faulty, dangerous procedures — like incomplete abortions — so they will have to be repeated at additional cost.

It has been estimated that between 5 and 10 percent of the nearly half-million doctors practicing in the United States are incompetent or unscrupulous.

We read about some of these people. Their outrages make headlines — like the specialist who was videotaped sedating a patient and preparing to rape her; or a psychiatrist who settled out of court after being accused of having sexual relations with his patients; or a so-called cancer doctor who sold "cures" to the terminally ill, taking the last of their money before they lost their lives.

A bad doctor may be mentally, professionally or physically incompetent, or suffering from ignorance or stupidity, according to Dr. Robert Derbyshire, former president of the Federation of State Medical Boards, in a report compiled by the Senate Special Committee on Aging last year. That first group — including impaired physicians whose safe, skillful practice of medicine is hampered by drunkenness, drug abuse, mental illness, disease or senility — is the largest, he says.

Unscrupulous doctors — the worst of the lot — are those who realize they are impaired but continue to do what they know they cannot do safely, or those who choose to practice bad medicine — like trading narcotics for sexual favors — for pleasure or profit.

Most people are not able to judge a physician's professional competence, so perhaps it's natural that they put greater weight on warmth, reassurance, effective communication and caring. From a patient's point of view, a doctor who makes you feel good is good.

But other doctors, in a better position to evaluate technical competence, look out for unreliability, sloppy practice, poor judgment, outmoded training or poor technique.

We doctors like to think that physicians no longer have to protect their own that way — that the conspiracy of silence is long past. But it's hard to tell.

"Either we're doing a fantastic job of choosing who will enter our medical schools, or we just aren't catching the bad one who make it through," wryly comments a physician and administrator who serves on the Education Evaluation Committee at George Washington University, the committee responsible for making determinations about the competence or professional comportment of medical students who get into trouble.

"You know, I greatly admire airline pilots," he adds. "They police themselves very seriously. They're required to be recertified for competence every six months. I wonder how many of us doctors, myself included, would be able to pass such exams."

Personally, I feel like a bad doctor more often than I'd like. Sometimes I fell inadequate; others, impotent. As this man lies dying, I'm plagued by both.

Colleagues, pained by difficult cases, have expressed the same feeling. Moreover, I think most good doctors actually do practice bad medicine occasionally. It is almost impossible to be appropriate all the time.

That's why, in trying to judge medical care, we have accepted the notion of "standard of care."

No one can be expected to solve every problem, get every diagnosis right. If a doctor offers at least the level of care in any situation offered by most doctors in the medical community, he's not considered to blame if the outcome is not good.

The principle sounds simple, but it isn't always. Sometimes there are are many appropriate approaches to a problem and none of them gives the right answer. Other times, the approach can be all wrong, the thinking off — but the problem gets solved anyway.

During my residency training, a young woman was admitted to my service by a private physician, with the diagnosis "fever of unknown origin." That is a technical diagnosis applied appropriately only under certain circumstances — not hers.

Four days earlier, this private physician had seen her in the office and she'd had a fever. When she called saying her temperature was still high, he simply admitted her to the hospital without reevaluating her first.

Young doctors in training are notoriously self-righteous about such cases; they think the outside physician hasn't done his homework. In this instance, I spoke for a few minutes with the woman, put a hand on her belly, swallowed my irritation and called her doctor to get the name of the surgeon he'd prefer. She had acute appendicitis.

"He got her into the hospital, where she needed to be, didn't he? And on time," another resident pointed out. "He must be doing something right."

Before my training ended, we came to regard that as a joke: There were two or three doctors whom we considered bizarrely reliable in that a person they admitted to our hospital always needed to be in there — but never for the reason the doctor considered to be the diagnosis.

Some of those doctors probably managed to keep out of trouble because they recognized their own limitations, I've since decided. When they didn't know what to do, they hospitalized someone or sent him to an expert.

Their training may not have been up to date, but they did know when someone was genuinely sick, and they knew how to signal for help when they required it.

The more I run into diagnostic puzzles myself, the less of that old self-righteousness I find I retain. It's still easy for me to censure bad doctors, but less simple to assume that inadequate medicine always means a bad doctor — sometimes its a good doctor who doesn't have all the answers.

Of course there are those utterly horrifying cases of doctors who end up killing their patients because of repeated ineptnes or venality. We wonder how these people ever made it through training and into practice without getting caught.

We read that their malfeasance actually took place over more than 10 years, or that they were sued for malpractice many times, and ask, astonished, "Didn't anyone complain? Why wasn't this person caught?"

For some, problems may have been evident in medical school. Every year, a few people get into trouble at George Washington because of poor academic performance or inappropriate professional behavior — cheating, shoplifting or taking drugs, for example.

Complaints against students that carry a threat of dismissal trigger investigations by the Education

Evaluation Committee. But the Committee needs concrete, adequate evidence of bad performance.

Not infrequently, lawsuits are brought against the medical school by those students who have been dismissed. They will go to all ends to gain reentry, and the legal actions are time-consuming and very expensive for the medical school.

"But we take our obligation to turn out competent, honest doctors extremely seriously," comments one of the medical school administrators. "We don't hesitate to act if we think the public would be threatened by inappropriate or unprofessional behavior on the part of one of our potential doctors."

A person whose drug abuse actually led her to demand a urine specimen from a patient to pass of as her own was dismissed several years ago. So was a person who falsified credentials to state she'd graduated from a professional school — she had actually dropped out. Others simply flunk out.

But even dismissal from medical school may fail to short-circuit the careers of people with problems. Almost all the medical students who have been dismissed in recent years at George Washington have ended up in off-shore medical schools, which can provide a path back into the American medical system. One we recently learned about quite by accident.

He was about to be fired from a residency program elsewhere, which he had entered without ever revealing that he'd been dropped from an American medical school. Persistent incompetence was what got him in trouble there — yet the residency program only discovered accidentally that he'd ever had problems before.

"You know, if we paid more attention to the reasons for program-hopping, or for doctors moving from state to state, we might do a more effective job of keeping these people out of medicine," one committee member commented. "But no matter what these people do, someone seems to write letter for them, recommendations that get them another spot."

In fact, according to Derbyshire, sometimes an agreement with an incompetent doctor to get him out of a hospital or a state includes concealment of malfeasance or providing good recommendations.

One reason so few doctors are drummed out of the system is that others are often reluctant to come forward and testify for fear of a retaliatory slander suit.

A doctor who did file complaints in a case involving illegal abortions and serious injury to some of the victims says ruefully, "I did it because I think it was right and I was the appropriate person. But I'll tell you, I got threatening phone calls every night until this man finally surrendered his license — and the FBI told me if anyone suspicious came too close to my house, I should take out my rifle and shoot."

This doctor became involved when information was brought to him about a woman who'd had an abortion that appeared to be botched in a number of ways. First, the abortion was attempted much too late in the pregnancy — the fetus might have lived.

Moreover, the membranes protecting it had been ruptured, creating a massive infection that proved fatal to the fetus. He reported the case to the police, but the doctor involved was not prosecuted at the time.

Months later, another woman, with a pelvic abscess and a disfigured vagina after a botched abortion by the same doctor, came to GW seriously ill. On top of everything else, this doctor had given her the wrong antibiotics.

This time, the George Washington staff doctor went to the head of the District of Columbia Healing Arts Commission — the board that licenses District doctors and hears complaints against them. A year later, the physician at fault finally surrendered his license.

Over the years, the Healing Arts Commission has been plagued by too little money — from 1977 through 1983 there were just 11 such cases. But this year, with better funding from the city government, and the staff attorney they have desperately needed, the commission has already held six hearings in the last seven months; six more are scheduled and eight others are planned.

Even with the increased hearings this year, however, the District barely meets the 1981 annual average per state of about 11 actions with serious consequences — loss of license or probation. And those actions represented investigation of less than one percent of doctors assumed to be incompetent, Derbyshire says.

One commission staff person adds, "Some have begun to say that maybe a requirement of getting your license should be that a doctor be required to step forward and testify" if he sees wrongdoing.

In Arizona, where physicians are compelled to report malfactors and are legally immune from suits, the number of reports has quadrupled.

Another George Washington doctor, one who testified recently in a case concerning the competence of a heart and lung surgeon, says flatly, "If we don't police ourselves, somebody else is going to do it for us. Most of us do feel we need some kind of internal policing — but, of course, 'bounty hunters' are not highly regarded."

I think to myself that were I put in the position, I would find it difficult to do my duty and testify. I remember ruefully how difficult it is for me to make critical comments about residents and medical students I've come to know and like. I am glad I've not been tested by circumstance, I conclude.

On graduation day for the medical school, 152 new doctors solemnly repeat the words of the Hippocratic Oath — "Do no harm." I cannot help wondering: Will they all be good? Did we catch the problem people? Did anyone who shouldn't have slip through? We'll find out, but maybe not soon enough.

Carole Horn, M.D.
Washington, D.C.

Reprinted with permission from *The Washington Post National Weekly Edition*, July 15, 1985.

Remember May at the FMA

Remember May at the FMA
No longer will we have that day
The meeting is moving to September
But still the Mays we will long remember.

Driving to the Americana or Diplomat
The car getting hotter as we sat
Waiting our turn for some bellhop
As patient physicians, not ever blowing our top.

Remember the white sands, palms and sun,
Business and pleasure — all of it fun
So many meetings from which to choose
At times our minds we did lose.

Meetings of all physicians merged into one
Colleagues together ever on the run
Thanks to Mrs. Trask and the Polk County Suite
Polk County Delegates had a place to relax their feet.

May — September the month may be different
But the same ideals and goals continue unbent
Mark your calendars and be sure to go
Then your memories, like mine, will continue to grow.

Robert B. Peddy, M.D.
Lakeland

Reprinted with permission from *The Bulletin of the Polk County Medical Association*, June, 1985.

SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

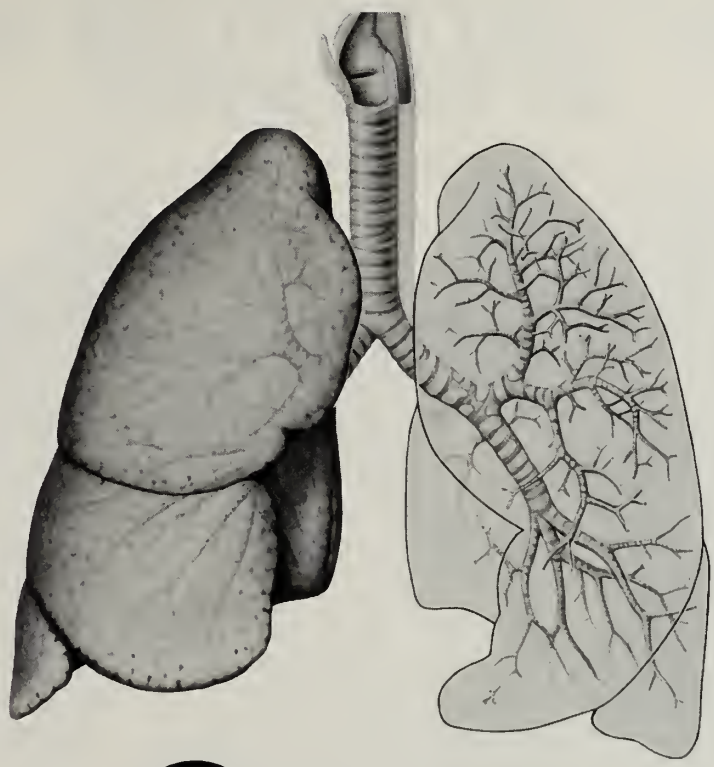
A recent Federal Court case brought this scam to light. A review of appropriate files indicates this scam has been used by a number of physicians, dentists and veterinarians.

A physician will present himself to a pharmacist and using his own prescription blank or one of the pharmacies, write a prescription for himself for a controlled drug (while this is not illegal there is some question as to whether it is ethical). Perhaps the physician will write a prescription in the name of a patient telling the pharmacist he will deliver the controlled drug to the patient; or the physician's receptionist will present a number of controlled drug prescriptions in the names of various patients to the pharmacist and take the drugs back to the office. Occasionally a patient will present a controlled drug prescription to the pharmacist and upon having it filled, return it to the doctor's office (telling the pharmacist the doctor requested it for safekeeping).

The first two situations may not be illegal but are usually indicators of possible personal addiction on the part of the doctor. The second two situations are usually absolutely indicative of either personal addiction or illicit drug sales on the part of the physician. Both of these situations are also felony violations of the controlled substances law.

Caution •Pharmacists are reminded that Controlled Drug prescriptions can only be dispensed to the person whose name appears on the prescription. Family members who present prescriptions for other members of the family might be considered acting as agents for the person named on the controlled drug prescription and would therefore be in legal possession, although this situation depends upon the circumstances. However, in just about every other case, anyone in possession of controlled drugs with another person's name on it is in felony violation of the controlled substances law.

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, H. influenzae, S. pneumoniae, S. pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary: Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbiliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0617B2R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

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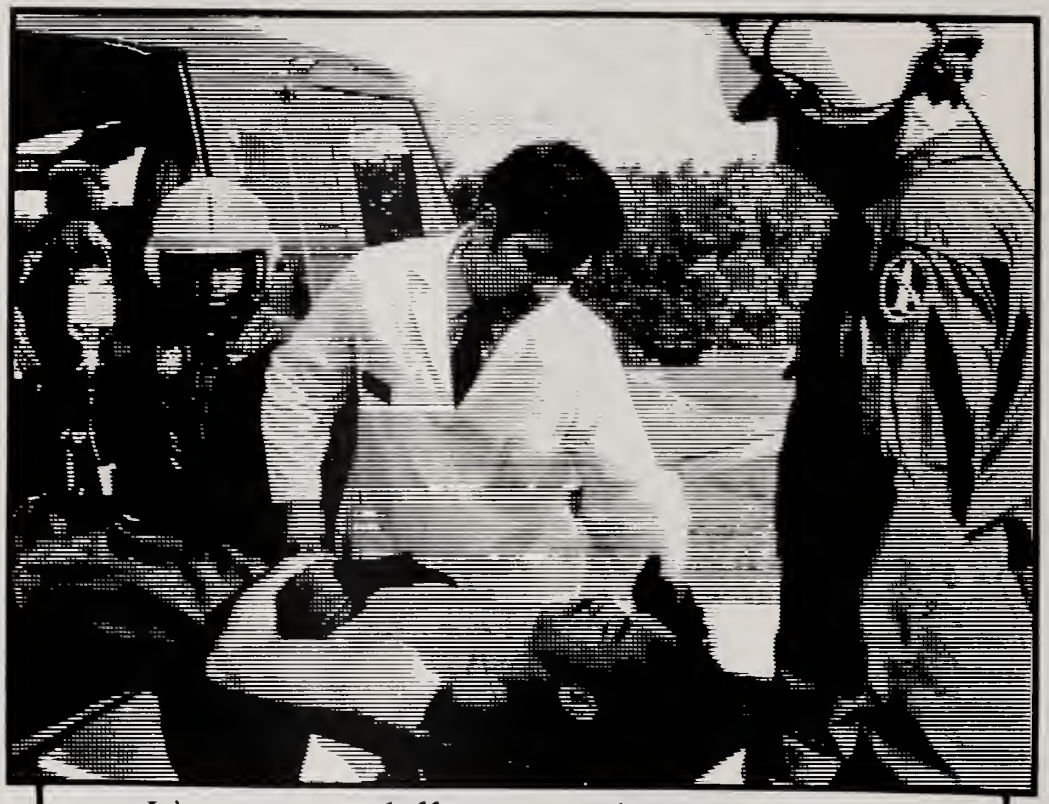
PHYSICIANS, A WEEKEND WITH THE RESERVE ISN'T JUST ANOTHER DAY AT THE OFFICE.



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BOOK REVIEW

Book Review Editor — F. Norman Vickers, M.D.

The psyche wards, from behind a psychiatrist's door

By Russell C. Packard, M.D., 228 pages. Price $14.95. P.S. Eriksson.

Russell Packard has displaced Robert Ludlum as my favorite author. . .at least for now. In Packard's latest book, *The Psych Wards*, he portrays the many emotional ups and downs of a first year resident in psychiatry. No holds are barred as he frankly describes his own turmoil in dealing with the cross section of characters in a large naval hospital. Anyone who has seen service in a military hospital will quickly recognize the stuffed-shirts, the militant facades, the menagerie of patients one must deal with. Packard does it all. His descriptions are vivid, his insight superb. This elderly reviewer can reminisce happily at the word pictures Packard draws. Knowledgeably he points out that the learning process for the doctor comes primarily from his patients, not the boring lectures he must attend. The tremendous variations in personalities the young psychiatrist encounters are vividly described. His own reactions are frankly stated and one can suffer with him at the never ending stream of young "sickies" he must treat. The book is a series of vignettes covering more than a year in a field he finally decides is not for him. Humor is woven into his analytical efforts to treat his many patients and pathos seeps through as early confusion matures into recognized unhappiness. Any physician who harbors the mistaken idea that psychiatry is a breeze will come to a rude awakening as he reads the suffering and conflicts Packard describes so beautifully. Read it and enjoy the work of a young master.

Philip B. Phillips, M.D.
Pensacola

- Dr. Phillips is a practicing psychiatrist in Pensacola.

A to Z of women's health

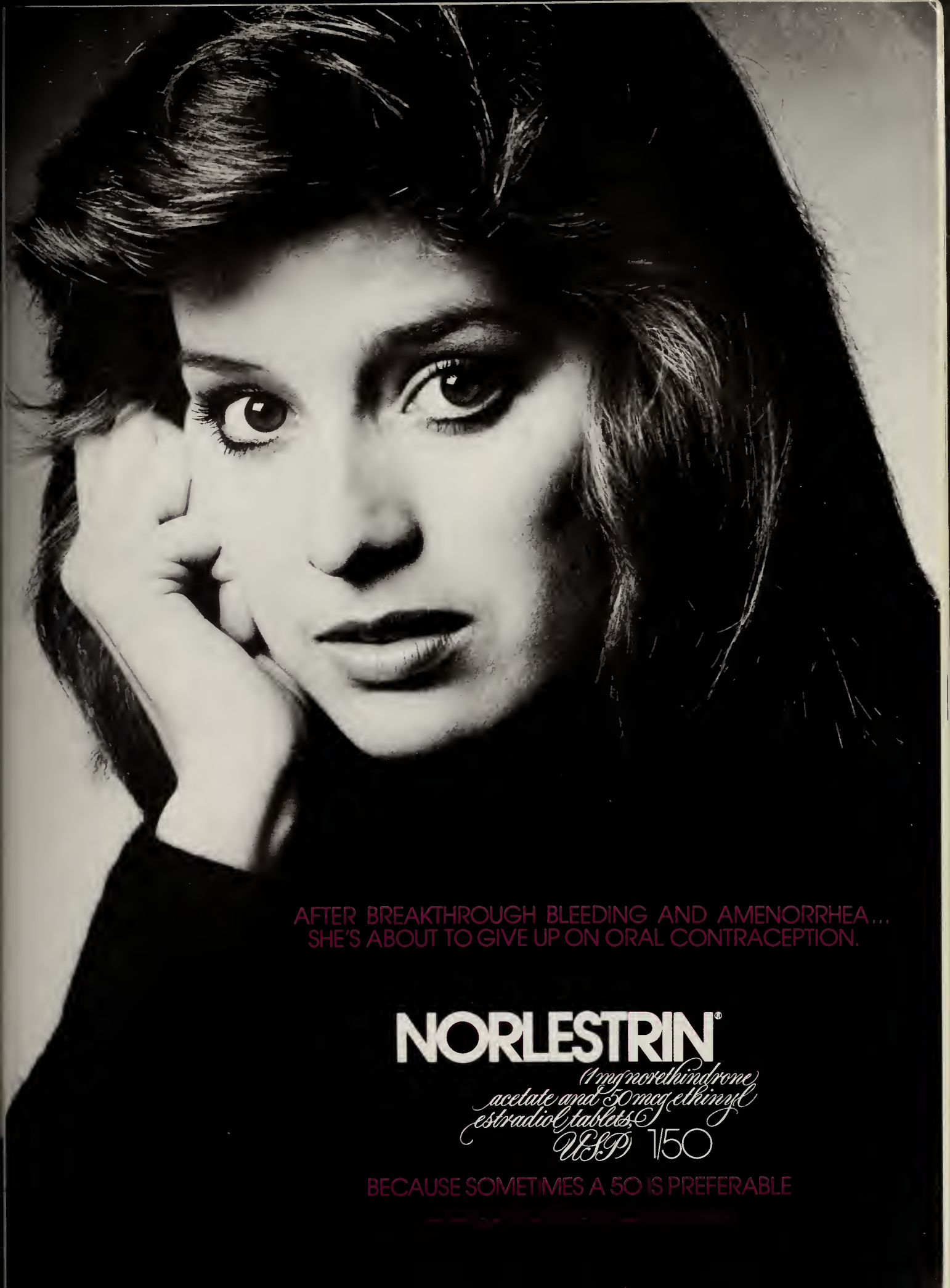
By Christine Ammer, 481 pages. Price $19.95. Facts on File.

The book *A to Z* is an extensive survey of gynecologic and obstetrical terms. It is at once too complex and too simple for a specific audience. Its detail is considerably more than would be desired by most casual readers of women's articles and yet it is beneath the level of scientific evaluation which would make it of use to trained professionals. It would seem to me that this book's best use would be in the office of those people interested in female health so that people beneath the level of R.N. might better comprehend dictation from the doctor or diagnoses given by the physician. It has a bias which is reflected in several areas; for instance, a description of mini-laparotomy as being safer and easier and less painful than laparoscopy. Basically, it

will be found to be a useable book by mid-level health care personnel. The completeness of the book is to be applauded. The narrowness of application for the proposed reader would make this a useful but certainly not a widely used book. It may have a limited appeal for those women's movements in which it has now become a desirable tool to use correct terminologies to present to the physician or other health professional. Again, this is an encyclopedic handling of a narrow area of women's terminology in disease of use to mid-health delivery personnel beneath the level of the true professional and a little too complicated for the average patient.

Doris N. Carson, M.D.
Jacksonville

- Dr. Carson has a practice in obstetrics and gynecology in Jacksonville.


AFTER BREAKTHROUGH BLEEDING AND AMENORRHEA...
SHE'S ABOUT TO GIVE UP ON ORAL CONTRACEPTION.
NORLESTRIN®
(1 mg norethindrone acetate and 50 mcg ethinyl estradiol tablets, USP) 1/50
BECAUSE SOMETIMES A 50 IS PREFERABLE

Brief Summary of Prescribing Information
NORLESTRIN® (norethindrone acetate and ethinyl estradiol tablets, USP)

See section under **Special Notes on Administration and HOW SUPPLIED.**
Before prescribing, please see full prescribing information. A Brief Summary follows

DESCRIPTION
Norlestrin Products are progestogen-estrogen combinations

INDICATIONS AND USAGE
Norlestrin Products are indicated for the prevention of pregnancy in women who elect to use oral contraceptives as a method of contraception

In clinical trials with Norlestrin 1/50 involving 25,983 therapy cycles, there was a pregnancy rate of 0 05 per 100 woman-years; in clinical trials with Norlestrin 2 5/50 involving 96,388 cycles, there was a pregnancy rate of 0.22 per 100 woman-years

Dose-Related Risk of Thromboembolism from Oral Contraceptives: Studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism If is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen The oral contraceptive prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance

CONTRAINDICATIONS
1 Thrombophlebitis or thromboembolic disorders
2 A past history of deep-vein thrombophlebitis or thromboembolic disorders
3 Cerebral vascular or coronary artery disease
4 Known or suspected carcinoma of the breast
5 Known or suspected estrogen-dependent neoplasia
6. Undiagnosed abnormal genital bleeding
7 Known or suspected pregnancy (See WARNING No 5)
8. Benign or malignant liver tumor which developed during the use of oral contraceptives or other estrogen-containing products

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. The risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks

1 *Thromboembolic Disorders and Other Vascular Problems* An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well-established Studies have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic

Cerebrovascular Disorders: In a collaborative study in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2 0 times greater in users than nonusers, and the risk of thrombotic stroke was 4 0 to 9 5 times greater

Myocardial Infarction: An increased risk of myocardial infarction associated with oral contraceptives has been reported confirming a previously suspected association These studies found that the greater the number of underlying risk factors (cigarette smoking hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia) for coronary artery disease, the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not Oral contraceptives, however, were found to be a clear additional risk factor

It has been estimated that users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke Oral contraceptive users who are smokers have about a fivefold increased risk of fatal infarction compared to users who do not smoke, but about a tenfold to twelvefold increased risk compared to nonusers who do not smoke The amount of smoking is also an important factor

Risk of Dose: In an analysis of data, British investigators concluded that the risk of thromboembolism, including coronary thrombosis, is directly related to the dose of estrogen used in oral contraceptives, however, the quantity of estrogen may not be the sole factor involved

Persistence of Risk: Two studies have suggested that an increased risk may persist for as long as 6 years after discontinuation of oral contraceptive use for cerebrovascular disease and 9 years for myocardial infarction In addition, a prospective study suggested the persistence of risk for subarachnoid hemorrhage

Estimate of Excess Mortality from Circulatory Diseases: The risk of diseases of the circulatory system is concentrated in older women in those with a long duration of use, and in cigarette smokers

A study of available data from a variety of sources concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke

The risk of thromboembolic and thrombotic diseases associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia, and especially by cigarette smoking

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders Should any occur or be suspected, the drug should be discontinued immediately

A fourfold to sixfold increased risk of postsurgery thromboembolic complications has been reported in users If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization

2 *Ocular Lesions* Neuro-ocular lesions, such as optic neuritis or retinal thrombosis, have been associated with the use of oral contraceptives Discontinue the oral contraceptive if there is unexplained sudden or gradual, partial, or complete loss of vision, onset of proptosis or diplopia, papilledema, or retinal vascular lesions

3 *Carcinoma* Long-term continuous administration of estrogen in certain animal species increases the frequency of carcinoma of the breast cervix vagina and liver

In humans, an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women has been reported However, there is no evidence suggesting increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives

Studies found no evidence of increase in breast cancer in women taking oral contraceptives, however, an excess risk in users with documented benign breast disease was reported

There is no confirmed evidence of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of users is, nevertheless, essential In cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy Women with a strong family history of breast cancer, or who have breast nodules, fibrocystic disease or abnormal mammograms, should be monitored with particular care

4 *Hepatic Tumors* Benign hepatic adenomas have been found to be associated with oral contraceptives Because hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage, they should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives The relationship of these drugs to this type of malignancy is not known at this time

5 *Usage in or Immediately Preceding Pregnancy, Birth Defects in Offspring, and Malignancy in Female Offspring* During early pregnancy, female sex hormones may seriously damage the offspring

An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of oral contraceptives in pregnancy

There is some evidence that triploidy and possible other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives

Pregnancy should be ruled out before continuing an oral contraceptive in any patient who has missed two consecutive menstrual periods If the patient has not adhered to the schedule, the possibility of pregnancy should be considered at the time of the first missed period and oral contraceptives should be withheld until pregnancy has been ruled out If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed

Women who discontinue oral contraceptives with the intent of becoming pregnant should use an alternate form of contraception for a period of time before attempting to conceive

Administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy

6 *Gallbladder Disease* Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives

7 *Carbohydrate and Lipid Metabolic Effects* Because decreased glucose tolerance has been observed in a significant percentage of patients, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives

An increase in triglycerides and total phospholipids has been observed

8 *Elevated Blood Pressure* An increase in blood pressure has been reported in patients receiving oral contraceptives The prevalence in users increases with longer exposure Age is also strongly correlated with development of hypertension Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure

9 *Headache* Onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent or severe, requires discontinuation of oral contraceptives

10 *Bleeding Irregularities* Breakthrough bleeding spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives In breakthrough bleeding nonfunctional causes should be borne in mind In undiagnosed abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy

Women with a past history of oligomenorrhea or secondary amenorrhea, or young women without regular cycles should be advised that they may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives

11 *Ectopic Pregnancy* Ectopic as well as intrauterine pregnancy may occur in contraceptive failures

12 *Breast-Feeding* Oral contraceptives may interfere with lactation Furthermore a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs

PRECAUTIONS
1 A complete medical and family history should be taken prior to the initiation of oral contraceptives The pretreatment and periodic physical examinations should include special reference to blood pressure breasts, abdomen, and pelvic organs, including Papanicolaou smear and relevant laboratory tests As a general rule, oral contraceptives should not be prescribed for longer than one year without another examination

2 Preexisting uterine leiomyomata may increase in size

3 Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree

4 Oral contraceptives may cause fluid retention and should be prescribed with caution, and only with careful monitoring in patients with conditions which might be aggravated

5 Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice If jaundice develops, the medication should be discontinued

6 Steroid hormones may be poorly metabolized and should be administered with caution in patients with impaired liver function

7 Users may have disturbances in normal tryptophan metabolism, which may result in a relative pyridoxine deficiency

8 Serum folate levels may be depressed

9 The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted

10 Certain endocrine and liver function tests and blood components may be affected
(a) Increased sulfobromophthalein retention (b) Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3, increased norepinephrine-induced platelet aggregability (c) Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone (d) Decreased pregnanediol excretion (e) Reduced response to metyrapone test

Drug Interactions: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin A similar association has been suggested with barbiturates phenylbutazone, phenytoin sodium, tetracycline, and ampicillin

ADVERSE REACTIONS
An increased risk of the following serious adverse reactions has been associated with oral contraceptives thrombophlebitis, pulmonary embolism, coronary thrombosis; cerebral thrombosis, cerebral hemorrhage, hypertension; gallbladder disease, benign hepatomas, congenital anomalies

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed mesenteric thrombosis, neuro-ocular lesions, eg, retinal thrombosis and optic neuritis

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related nausea and/or vomiting, usually the most common adverse reactions, occur in approximately 10% or less of patients during the first cycle Other reactions, as a general rule, are seen much less frequently or only occasionally gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea amenorrhea during and after treatment, temporary infertility after discontinuance of treatment, edema, chloasma or melasma, breast changes, change in weight, change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum, cholestatic jaundice, migraine, increase in size of uterine leiomyomata, rash (allergic), mental depression, reduced tolerance to carbohydrates; vaginal candidiasis, change in corneal curvature, intolerance to contact lenses

The following adverse reactions have been reported and the association has been neither confirmed nor refuted premenstrual-like syndrome; cataracts, changes in libido, chorea, changes in appetite; cystitis-like syndrome, headache, nervousness, dizziness; hirsutism, loss of scalp hair erythema multiforme; erythema nodosum, hemorrhagic eruption, vaginitis, porphyria

Special Notes on Administration
Menstruation usually begins two or three days, but may begin as late as the fourth or fifth day, after discontinuing medication

After several months on treatment, bleeding may be reduced to a point of virtual absence; reduced flow may be a result of medication and not indicative of pregnancy

HOW SUPPLIED
Norlestrin [21] 1/50 is available in compacts each containing 21 tablets Each tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol Available in packages of five compacts and packages of five refills

Norlestrin [21] 2 5/50 is available in compacts each containing 21 tablets Each tablet contains 2 5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol Available in packages of five compacts and packages of five refills.

Norlestrin [Fe] 1/50 is available in compacts each containing 21 yellow tablets and 7 brown tablets Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol Each brown tablet contains 75 mg of ferrous fumarate, USP Available in packages of five compacts and packages of five refills

Norlestrin [FE] 2 5/50 is available in compacts each containing 21 pink tablets and 7 brown tablets Each pink tablet contains 2 5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol Each brown tablet contains 75 mg of ferrous fumarate, USP Available in packages of five compacts and packages of five refills

Norlestrin [28] 1/50 is available in compacts each containing 21 yellow tablets and 7 white inert tablets Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol Available in packages of five compacts and packages of five refills

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PD-21-JA-2563-P-1(11-84)

BALANCED CALCIUM CHANNEL BLOCKADE!

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

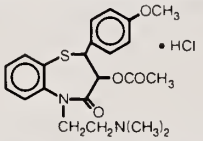
Please see full prescribing information on following page. 2/84

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGDT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGDT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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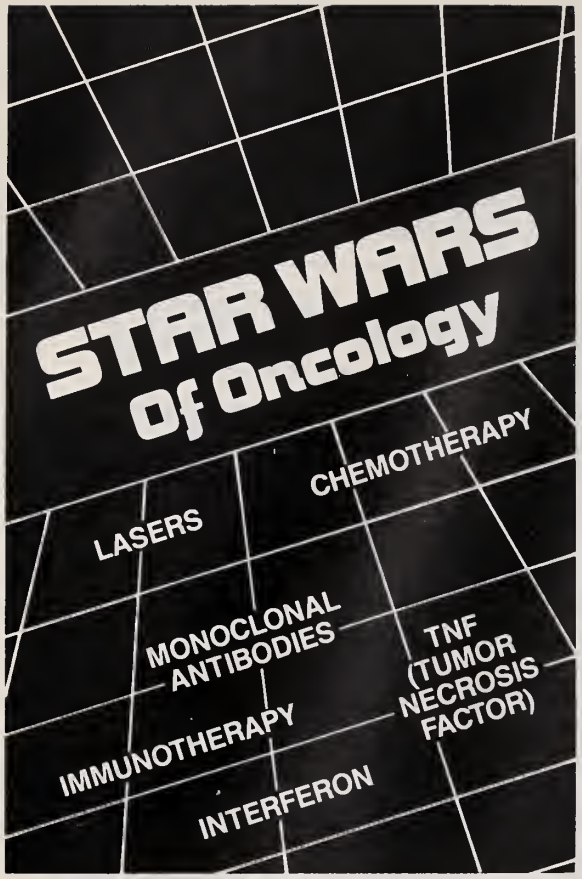

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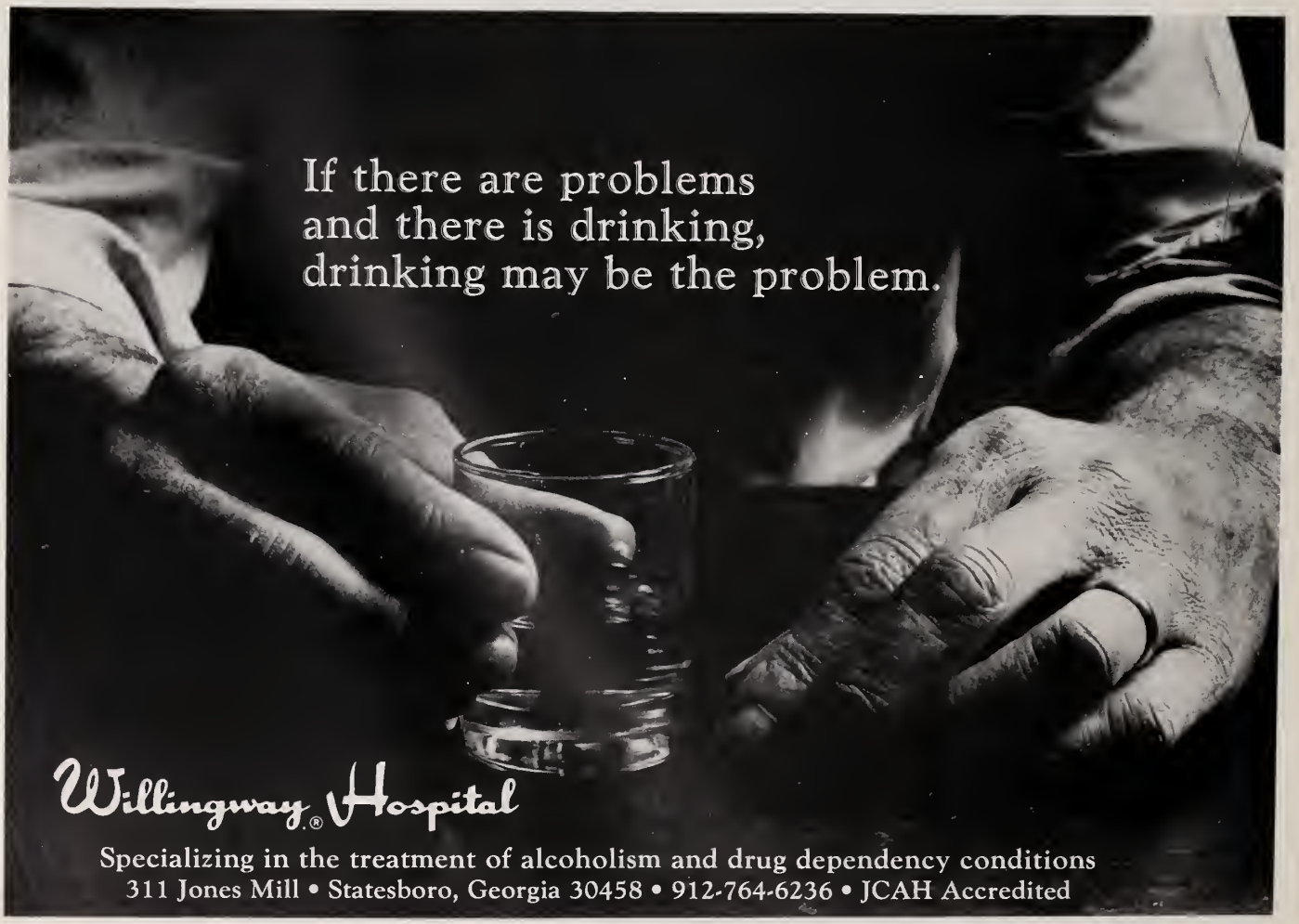
Thomas C. Merigan, M.D.—Chief, Division of Infectious Diseases, Stanford University—"Immunotherapy of cancer in its broadest aspects. Interferon. Monoclonal antibodies."
John McDonald, M.D.—Chairman, Oncology Department, University of Kentucky—"Defense establishment of medicine . . . oncology. Recent developments in tumor therapy with emphasis on those tumors which are impressively benefited by therapy."



Auxiliary Liaison Editor — **Mrs. Walter (Isabella) Laude**

The orange jackets

The scene was a crowded convention hall of the Drake Hotel in Chicago. It was the Annual Meeting of the American Medical Association Auxiliary. Over 350 officers, chairmen, delegates, and guests had gathered for this 62nd Annual Session. How to find anyone in this grand assembly could pose a problem, but not for the Florida Delegation. Each Florida delegate was quickly and joyfully recognized by her bright orange jacket.

All nineteen delegates were in high visibility at every function. They assisted with the activities of the Florida Medical Association and were there to help honor former FMA President, Rufus Broadaway, M.D., who is an AMA Trustee and President of the American Medical Association Education and Research Foundation.

It began with the roll call of states and ended with the Missouri reception honoring the newly installed AMA Auxiliary President, Mrs. William R. McPhee of Kansas City. The orange jackets were seen at reference committee hearings, and actively participated in the proceedings. They stood at attention and in pride to hear Immediate Past FMA Auxiliary President, Nancy Smith report on Auxiliary activities in legislative affairs, the Medi-File, the Governor's Committee on Aging, and in promoting the Research Center for Alzheimer's Disease.

The orange jackets were seen on stage accepting outstanding AMA Auxiliary awards for the best county newsletter in its category, Dade County, and for the best county newsletter in all the states, Dade County. Congratulations to Dade County and its editor, Emily Dabby!

For total contributions to AMA-ERF, the Florida Auxiliary was awarded second place, $112,354.39. First place went to California for a total contribution of $123,866.18. A check in the amount of $1,897,745.76 was presented to the AMA-ERF as the AMA Auxiliary contribution by the Auxiliary President, Mrs. Wayne C. Brady of South Carolina.

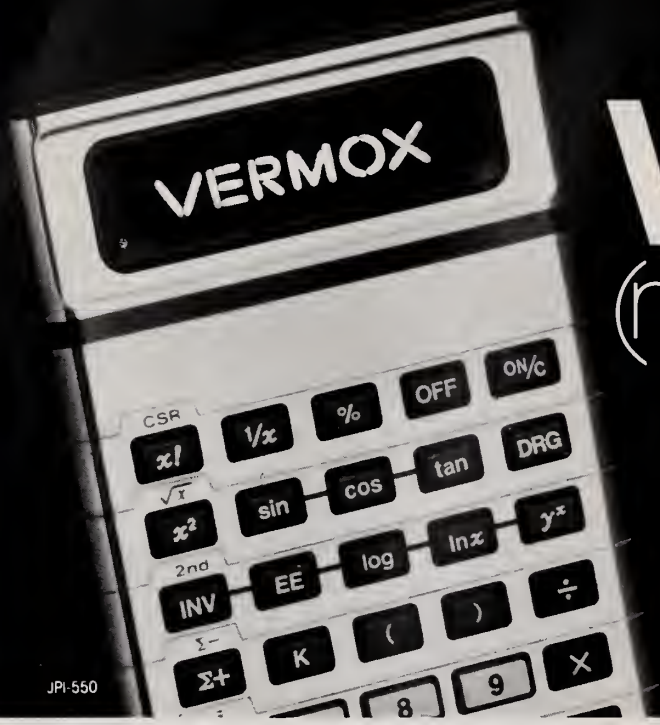
FMA-A Delegates to the AMA-A Annual Convention lead by Mrs. Laurin G. (Nancy) Smith, 84-85 President, and Mrs. Milton (Jo) Tignor, Chairman of the 19 Delegates.

Auxilians in the orange jackets were there to hear the keynote address on "Health Care in America" by Minnesota Senator David Durenberger; guest speaker, Uwe E. Reinhardt, Professor of Political Economy at Princeton on "The American Health Care Brawl: Will Anyone Win?" and to delight in the special symposium by noted author and lecturer, Florence Littauer on "How to Understand Others by Understanding Yourself." Political humorist, TV, radio and recording star, Mark Russell was the guest speaker at a luncheon honoring National Auxiliary Past Presidents and Honorary Members.

It was a busy time of meeting and learning, of friendship and fellowship. The orange jackets have been tucked away for another year, but the spirit of caring remains ever vigilant as the FMA Auxiliary moves forward in another year of showing that WE CARE.

Isabella Laude
Babson Park

No need for dosage calculations...



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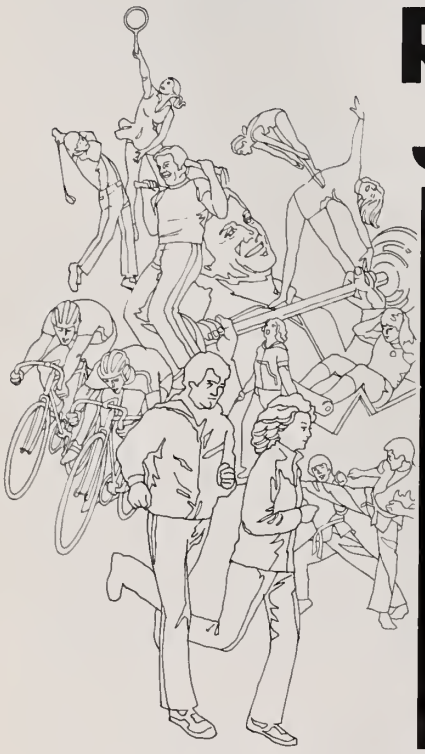

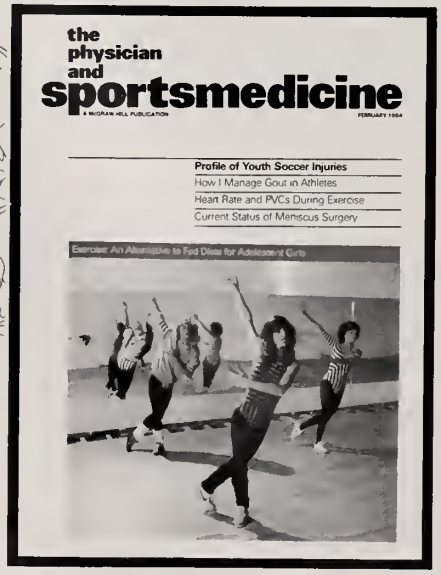

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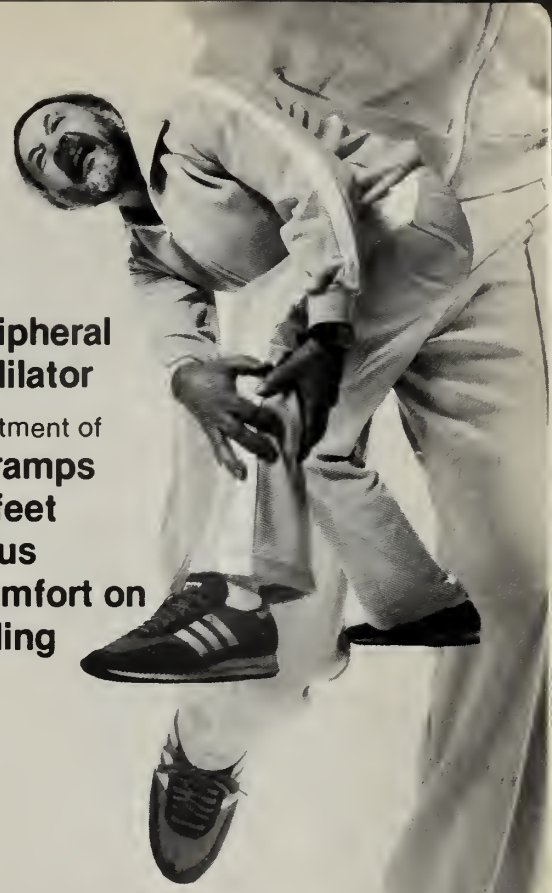

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Meetings

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SEPTEMBER

Current Concepts in the Management of Pain, Sept. 3, Holy Cross Hospital, Ft. Lauderdale. For more info: Joh Fichtelmar, M.D., 4725 N. Federal Hwy., Ft. Lauderdale, Fl. 33308. (305) 492-5728.

Physical Therapy Treatments/ Modalities, Sept. 10, Doctors' Hospital, Lake Worth. For more Info: Roberto Miguel, M.D., 2889 9th Ave. N., Suite 203, Lake Worth, Fl. 33461, (305) 965-3280.

Anxiety — Quest for Improved Therapy, Sept. 11, Holy Cross Hospital, Ft. Lauderdale. For more info: Joh Fichtelman, M.D., 4725 N. Federal Highway, Ft. Lauderdale, Fl. 33308, (305) 492-5728.

Current Concepts in the Management of Spina Bifida, Sept. 13-14, Sheraton St. Johns Hotel, Jacksonville. For more information: Carol Pitman, Nemour Children's Hospital, (904) 721-4230.

Annual Meeting of the Florida Assocation for Nutritional Support, Sept. 13-14, USF College of Medicine, Tampa. For more information: William Blackshear, M.D., 12901 N. 30th Street, Tampa, Florida 33612.

Current Concepts in the Diagnosis of Adult Heart Disease IV, Sept. 13-14, New World Inn, Pensacola. For more information: D. Bruce McGraw, M.D., P.O. Box 151, Pensacola, Fl. 32591-0151, (904)478-4121.

Calcium Channel Blocker Update, Sept. 13-15, Saddlebrook Resort, Wesley Chapel, Fl. For more info: Stephen Glasser, M.D., 12901 N. 30th Street, Tampa, Florida 33612.

Advanced Cardiac Life Support, Sept. 13-15, Marion Community Hospital, Ocala. For more information: Marion Community Hospital, Inservice Education Dept., 1431 S.W. First Ave., Ocala, 32671.

Clinical Essential in Cleft Lip and Cleft Palate, Sept. 19,University of South Florida, Tampa. For more information: David R. Dickson, P.O. Box 016960, Miami, Fl. 33101, (305) 547-6123.

Coronary Artery Disease, Sept. 20-21, PGA Sheraton, Palm Beach Gardens. For more information: Jo Ellen Brown, 3360 Burns Road, Palm Beach Gardens, 33410, (305) 622-1411, Ext. 518.

International Symposium on Gynecologic Oncology, Surgery and Urology, Sept. 23-27, Germany. For more info: William A. Little, M.D., Deparment of Obstetrics and Gynecology, P.O. Box 016960, Miami 33101, 305-549-6944.

Beta Blocker Therapy, Sept. 26, Indian River Memorial Hospital, Vero Beach. For more information: Candy May, 1000 36th Avenue, Vero Beach, Fl. 32960, (305) 567-4311.

Ninth Annual Medical Aspects of Aging, September 27-28, University of Florida, Gainesville. For information, call: Grace Wagner, JHMHC J-233, Gainesville 32610, (904) 392-3143.

Fractures of the Pelvis and Acetabulum, Ramada Renaissance Hotel, San Francisco, CA. For more information: Emile Letournel, M.D., 12901 N. 30th Street, Tampa, Florida 33612, (813) 974-3322.

OCTOBER

Treatment Options in Drug and Alcohol Abuse, Oct. 1, Holy Cross Hospital, Ft. Lauderdale. Contact: John Fichtelman, M.D., 4725 N. Federal Highway, Ft. Lauderdale, Fl. 33308, (305) 492-5728.

Medicolegal Issues in Obstetrics, Oct. 3-6, New York City, N.Y. For more info: Robert Kruppel, M.D., 12901 N. 30th Street, Tampa, Fl. 33612, (813) 251-3748.

The Professional and Chemical Dependency, Oct. 4, New World Landing, Pensacola. Contact: Brunie Emanuel, Route 2, Box 174, Gulf Breeze, Florida 32561, 932-9375.

Laser Surgery Training Course, Oct. 8-11, Contemporary Resort Hotel, Orlando. Contact: Douglas Dew, M.D., 1414 S. Kuhl Avenue, Orlando, Fl., 32806, (305) 841-5144.

1985 Fall Conference on Pediatric Trauma, Oct. 11-12, Orlando Airport Marriott, Orlando. Contact: Joan H. Pyle, Dept. of EMS, P.O. Box 1393, Orlando, Fl. 32802, (305) 420-3188.

1985 TNO-ISIR Meeting on the Interferon System, Oct. 13-18, Holiday Inn, Surfside, Clearwater. Contact: William Stewart, 12901 N. 30th Street, Tampa, Fl. 33612, 813-974-2178.

Eleventh Annual PanAmerican Seminar, Oct. 14-18, Mount Sinai Medical Center, Miami Beach. For more info: Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, 33140, (305) 674-2311.

Calcium Channel Blockers New Concepts, Oct. 16, Lincoln Hotel, Tampa. Contact: Stephen Glasser, M.D., 12901 N. 30th St., Tampa, Fl. 33612, (813) 974-2880.

Advanced Neuroradiology Seminar, October 16-19, Hilton Hotel, Lake Buena Vista. For information: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813) 974-2538.

First Annual Conference on Clinical Problems in Primary Care, Oct. 18, USF College of Medicine, Tampa. Contact: Joseph Finster, M.D., 12901 N. 30th Street, Tampa, Florida 33612, (813) 974-4296.

Third Annual Meeting of the Vitreous Society, October 23-26, Contemporary Hotel, Lake Buena Vista. Contact: W.S. Grizzard, M.D., 12901 N. 30th Street, Tampa, Fl. 33612, 813-875-6373.

Pain Management Conference, Oct. 24-26, Royal Plaza Hotel, Orlando. Contact: Marge Duchano, R.N., Orlando Regional Medical Center, 1414 S. Kuhl Avenue, Orlando, Fl. 32806, (305) 841-5144.

Thirty-ninth Regional Family Practice Weekend, October 25-27, Marriott Biscayne Bay Hotel, Miami. For information: Charles A. Dunn, M.D., 4057 Carmichael Ave., Suite 229, Jacksonville 32207, (904) 398-5667.

Fall 1985 Family Practice Review, Oct. 27-Nov. 2, Orlando. Contact: Grace Wagner, JHMHC, J-233, Gainesville, Fl. 32610, (904) 392-3143.

Ninth Annual Medical Aspects of Aging, October 27-28, University Centre Hospital, Gainesville. For information: James A. Jernigan, M.D., JHMHC-J-233, Gainesville, 32610, 904-392-4321.

Fall 1985 Family Practice Review, Oct. 28-Nov. 1, Palace Hotel, Lake Buena Vista. For information: Lamar Crevasse, M.D., JHMHC J-233, Gainesville, 32610, (904) 392-3143.

Clinical Applications for Pulsed, Continuous Color Flow Doppler Echocardiography, Oct.31-Nov. 1, Mount Sinai Medical Center, Miami Beach. For information: Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, 33140, (305) 674-2311.

Nutrition In Pediatric Practice, October 30-November 1, Don Cesar Resort, St. Petersburg. For information: Herbert Pomerance, M.D., 12901 N. 30th Street, Box 15, Tampa 33612, 813-974-4214.

11th Annual S.E. Conference on High Blood Pressure, Oct. 30-Nov. 1, Las Palmas Inn, Orlando. Contact: James C. Bailey, 1317 Winewood Blvd., Tallahassee, Fl. 32301, (904) 488-2901.

NOVEMBER

Twenty-sixth Workshop in Electrocardiography, Nov. 1-4, Sheraton Sand Key Hotel, Clearwater. For information: Henry Marriott, M.D., 601 12th Street N., St. Petersburg 33705, (813) 894-0790.

Advanced Cardiac Life Support, Nov. 2-3, USF College of Medicine, Tampa. For more information: J. Paul Michlin, M.D., 12901 N. 30th St., Tampa, Fl. 33612, (813) 251-6911.

Spinal Deformities, November 3-6, Sheraton Bal Harbour, Bal Harbour. For information: Barry Silverman, 2050 N.E. 163rd Street, N. Miami Beach 33162, (305) 944-4746.

Current Advances in Perinatology, Nov. 3-9, Virgin Islands. Contact: Charles R. Bauer, M.D., Division of Pediatrics, P.O. Box 016960, Miami, Fl. 33101, (305) 547-5808.

Eleventh Annual Review Courses in OB/GYN, Nov. 13, Miami. Contact: Patty Mundy, P.O. Box 016960, Miami, Fl. 33101, (305) 549-6944.

Third Annual Childrens Hospital Foundation — Care of the Sick Child, Nov. 14-16, Palace Hotel, Lake Buena Vista. Contact: Joseph Chiaro, M.D., 1414 S. Kuhl Ave. Orlando, Fl. 32806, (305) 841-5143.

Eleventh Annual OB/GYN Reveiw Courses, Nov. 14-25, Sheraton Royal Biscayne Hotel, Key Biscayne. Contact: Patti Mundy, P.O. Box 016960, Miami, Fl. 33101, (305) 549-6944.

Ninth Annual Seminar: Evolution in the Total Care of the Pediatric Hematology/Oncology Patient, November 21-23, Hyatt Orlando, Orlando. For information: Cindi Butson, P.O. Box 13372, University Station, Gainesville 32604, 904-375-6848.

DECEMBER

Techniques of Therapeutic Gastrointestinal Endoscopy, December 4-6, Contemporary Resort Hotel, Lake Buena Vista. For info: H. Worth Boyce Jr., M.D., USF College of Medicine, Box 19, 12901 N. 30th Street, Tampa 33612 (813) 974-2034.

Innovative and Controversial Strategies in Rehabilitation II: Technology and Techniques, Dec. 4-8, Sheraton Bal Harbour, Miami. Contact: Gloria Allington, P.O. Box 016960, Miami, Fl. 33101, (305) 547-6716.

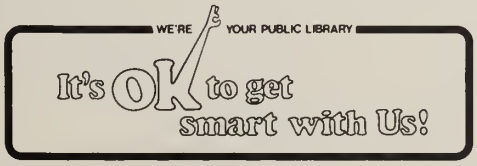
Clinical Allergy and Immunology for the Practicing Physician, Dec. 5-7, Palace Hotel, Lake Buena Vista. For info: Richard F. Lockey, M.D., VA Hospital, 13000 N. 30th St., Tampa, 33612, (813) 972-2000, ext.596.

Theoretical and Clinical Considerations Affecting the Selection of Neuroleptic Agents, December 6-7, Boca Raton Hotel, Boca Raton. For information: Millie Toberts, P.O. Box 016960, Miami 33101, 305-549-6327.

Ear, Nose, & Throat Diseases in Children, December 7-11, The Breakers, Palm Beach. For information: 125 DeSoto Street, Piladelphia, PA 15213, 412 647-5466.

Emergencies in Internal Medicine, VIII, Dec. 8-14, St. Thomas, Virgin Islands. For more information: Gloria Allington, P.O. Box 016960, Miami, Fl. 33101, 305-547-6716.

New Approaches to Common Disorders II, Dec. 11-14, Clearwater Beach. For information: Joel Gleason, M.D., 12901 N. 30th Street, Tampa, Florida 33612, (813) 397-5511.



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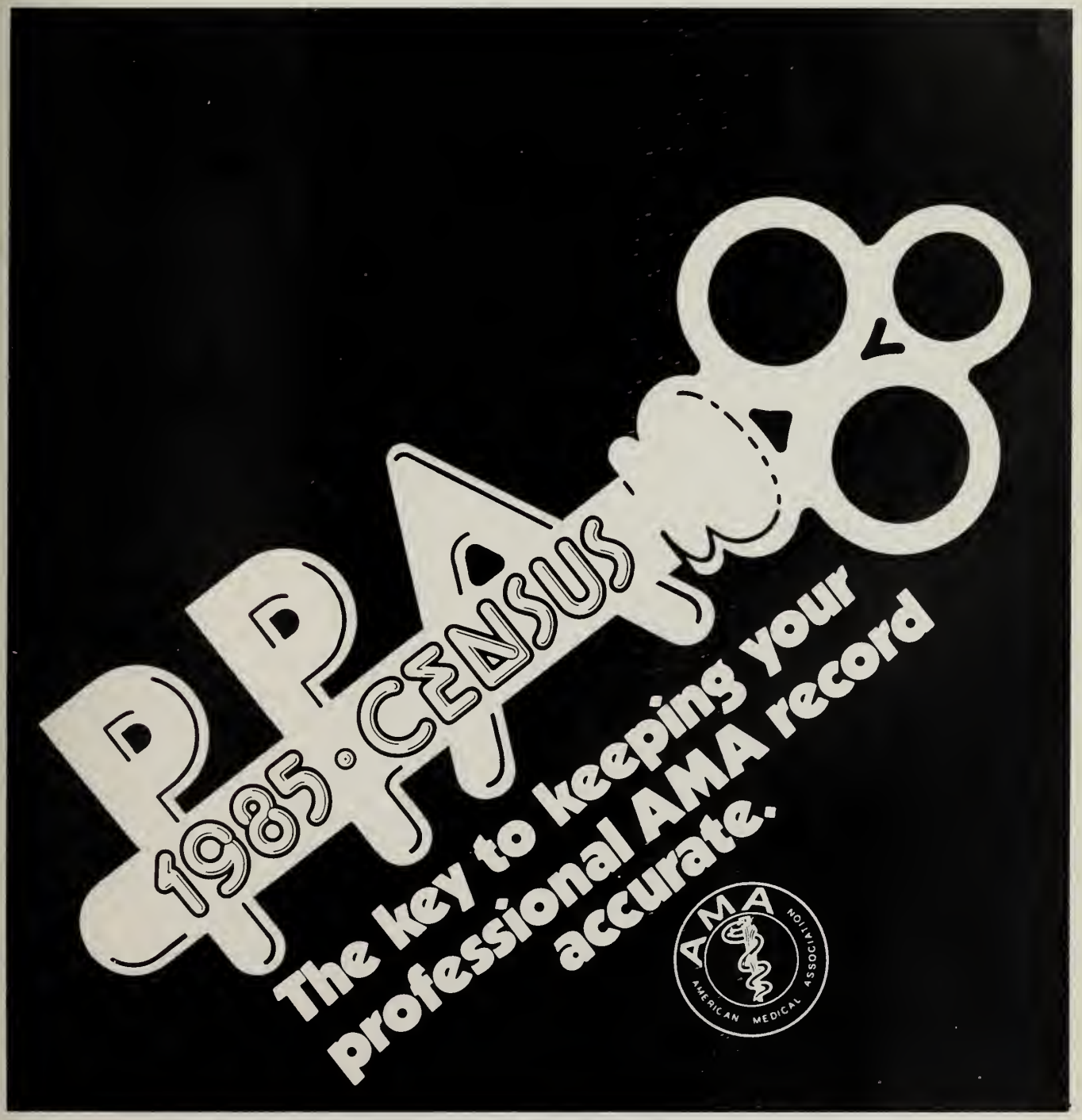

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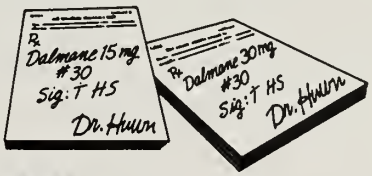

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